

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation)	
Against:)	
)	
LEROY AMAR, M.D.)	NO. D-1977
Physician's and Surgeon's)	
Certificate No. C28142,)	L-14064
)	
Respondent.)	
)	

DECISION AND ORDER

This matter came on regularly for hearing before John A. Willd, Administrative Law Judge with the Office of Administrative Hearings, at Los Angeles, California, on November 2, 1977, at the hour of 9:00 a.m. Dora Levin and Gayle M. Askren, Deputies Attorney General, appeared on behalf of the complainant, and at least one of the deputies was present at all times during the proceedings. The respondent, Leroy Amar, M.D., was personally present at all times during the proceedings and for a portion of the time he was represented by Henry Lewin, his attorney. This matter was heard on November 2, 3, 4, 7, 8, 9, 10, 14, and 15, 1977. The matter was again heard on January 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, and 20, 1978. Mr. Henry Lewin represented the respondent at all stages of the proceedings until January 4, 1978. On that date the respondent Leroy Amar substituted himself as counsel in this matter and Mr. Henry Lewin was relieved as counsel based upon the motion personally made by respondent. Thereafter, the respondent proceeded in propria persona although Mr. Henry Lewin did remain with respondent and did consult with him through January 6, 1978.

A proposed decision recommended by the Administrative Law Judge was non-adopted by the Division of Medical Quality. The Division proceeded to decide the case itself upon the record, including the transcript. The parties were afforded the opportunity to file written argument with the Division.

Having considered the matter, the Division now makes the following decision:

FINDINGS OF FACT

I

Joseph P. Cosentino, M.D. filed the Accusation and the First Supplemental Accusation herein in his capacity as the Acting Executive Director of the Board of Medical Quality Assurance.

II

On or about June 10, 1966 respondent Leroy Amar, M.D. was issued physician's and surgeon's certificate No. C28142 by the Board of Medical Examiners, the predecessor agency to the Board of Medical Quality Assurance. Said certificate is now and was at all times mentioned herein in full force and effect.

III

Sometime in July 1974 Ms. B████ contacted an organization known as Women Who Help Women. Ms. B████ spoke with a Mr. Dubin who was the principal directing force of the organization. Ms. B████ contracted for the following surgical procedures: Face lift, eyelid lift and repair of a deviated septum. On or about August 27, 1974 Ms. B████ went to a surgical facility at Stanton, California. Shortly after her arrival respondent introduced himself to Ms. B████ and he took some pre-operative photographs of her. Later respondent was present in the operating room and had a brief discussion with Ms. B████ concerning anesthetics she would receive. Respondent did not perform any surgical procedures on Ms. B████. The surgical procedures of face lift augmentation mammoplasty, eyelid lift and a surgical procedure on the nose of Ms. B████ were all performed by a Dr. Brown. Sometime later Ms. B████ did see Dr. Amar for postoperative care. She complained that something in one of her breasts had slipped and that she was unable to close her eyes. Respondent removed stitches and gave Ms. B████ some medication. Respondent did express his opinion to Ms. B████ that her breast implant was just settling in and that she would be able to close her eyes in time. The surgical results for Ms. B████ were not favorable. For several months following surgery she had a bad smell emanating from within her nose. The tip of her nose would turn blue and red particularly in cold weather. Her left breast has become very hard and she was unable to close her eyes for approximately six months following surgery. In addition she has very limited movement of her right eyebrow.

IV

In or about August 1974 M████ S████ contacted the organization known as Women Who Help Women and made inquiry about a breast lift. She spoke with Mr. Henry Dubin of that organization and she was assured that it was a rather simple procedure which they performed

all of the time. On one visit to the offices of Women Who Help Women her breasts were examined by Dr. John Brown and she was observed by respondent. On August 31, 1974 M████ S████ went to the medical facility at Stanton, California. She received no physical examination prior to surgery. She put on a gown which was provided for her and walked into the surgery room. Dr. Brown and the respondent were both in the operating room and respondent was introduced to M████ S████ as the assistant surgeon. Thereafter the patient was anesthetized and Dr. Brown performed breast surgery on M████ S████. Several days later M████ S████ returned to the offices of Women Who Help Women and her stitches were removed by Dr. Brown. The patient complained that her breasts were very sore but she was reassured that there were no problems. The patient was not given any medication.

V

On or about September 11, 1974 the patient M████ S████ developed an abscess in her left breast. She attempted to reach Dr. Brown but she was advised that he was in San Francisco. She attempted to reach the respondent and she was advised that Dr. Amar would return her call. This patient was not contacted by Dr. Amar. Shortly thereafter her infection ruptured and pus drained from the rupture. This patient went to another physician in order to take care of the infection. This patient was left with deformed breasts. They were uneven in size and became quite hard. Thus far she has received four surgeries in order to correct her condition. Medical records for this patient have never been located. It is not known whether or not medical records were ever prepared or kept for the patient M████ S████.

VI

In approximately September 1974 L████ S████ went to the offices of Women Who Help Women. There she spoke with Mr. Dubin and inquired about obtaining breast implants as well as the possibility of modifying her ears so they would lay closer to her head. L████ S████ also spoke with Dr. John Brown who visually examined her breasts and advised her that she could have breast implants. During this examination L████ S████ advised Dr. Brown that she did have a heart problem specifically that she had a prolapsed mitral heart valve. Because of this condition L████ S████ did consult her own physician and inquired whether she might undergo this surgery. Her physician was somewhat cautious but indicated that she might proceed with the surgery.

VII

On September 19, 1974 respondent performed an augmentation mammoplasty and an otoplasty on L████ S████. Prior to the surgery L████ S████ did advise respondent that she was suffering from a

heart problem. However, respondent did not conduct any physical examination of the patient prior to surgery other than taking a blood test.

VIII

On September 21, 1974 respondent examined L. S. and advised her that corrective surgery would be needed because her right breast was smaller than the left breast. Respondent also attempted to remove stitches in the ear; however, this procedure was quite painful and it was abandoned by respondent.

IX

On September 25, 1974 L. S. again went to the Stanton medical facility. At this point L. S. became most apprehensive concerning further surgery. She told respondent that she was afraid and did not wish to proceed. Respondent reassured L. S. and told her that there was nothing to this operation, that it would be a breeze. She was given no physical examination but she would from time to time receive a shot of some medication and this medication did tend to calm her. After waiting several hours the patient was ultimately taken into the operating room. L. S. was now very apprehensive. She advised respondent that her heart felt strange, that it was fluttering and that it was bothering her. She asked that someone check her heart and she again indicated that she did not wish to proceed with the surgery. Respondent again reassured L. S. and he told the nurse to proceed with the anesthetic. Respondent did remove the implant in the right breast of L. S. It was not established, however, that he replaced it with one of identical size.

X

L. S. does have a condition which is called pectus excavatum (sunken chest). By virtue of the shape of her chest it is true that there is some tendency for the breasts to gravitate toward the center of her chest; the end result, however, is not in this instance particularly abnormal and the patient is not dissatisfied with the implants from a cosmetic standpoint.

XI

The otoplasty performed by respondent on L. S. was not successful in that while the right ear was placed in a desirable position, the left ear was for some reason not substantially altered when compared to its pre-operative location.

XII

Sometime in approximately September 1974 H [REDACTED] B [REDACTED] went to the office of Women Who Help Women. There she spoke to one Kathleen Dubin and she told Mrs. Dubin that she was considering breast augmentation. Kathleen Dubin advised H [REDACTED] B [REDACTED] that the operation was a simple one which would take approximately forty-five minutes and there would be no discomfort. Mrs. Dubin stated that H [REDACTED] B [REDACTED] would be able to return to work in two or three days and there would be only a hairline scar following the operation. Later, Dr. Brown visually examined H [REDACTED] B [REDACTED] breast. Dr. Brown told H [REDACTED] B [REDACTED] that he would be assisted by Dr. Amar. H [REDACTED] B [REDACTED] then left the offices of Women Who Help Women and after discussing the matter with her husband she decided to have the surgery. Surgery for H [REDACTED] B [REDACTED] was scheduled for September 24, 1974 at Stanton, California. H [REDACTED] B [REDACTED] resides with her husband in San Fernando Valley. She decided for her own convenience to stay with her parents on the night of September 23 because her parents live in Orange County near the City of Stanton. On the evening of September 23, 1974 Ms. B [REDACTED] was contacted by a representative of Women Who Help Women by telephone. Ms. B [REDACTED] was advised that Dr. Brown was in San Francisco and would be unable to perform the operation on the following day. Ms. B [REDACTED] was directed to go to a medical facility in Reseda on the following morning and that a Dr. Berez would perform the augmentation mammoplasty. Dr. Berez did perform the surgery and four or five days later H [REDACTED] B [REDACTED] went to the offices of Women Who Help Women for postoperative care. At this point she was seen by respondent. The surgery performed by Dr. Berez was not satisfactory. The implants were improperly placed; the scar was too large; it was crooked and was too low so that it would be visible below a bra or halter top. Respondent advised Ms. B [REDACTED] that the surgery would have to be redone. There was some discussion concerning the possibility of removing the implants at this point permitting the incision to heal and then redoing the surgery at some future time. Ms. B [REDACTED] did indicate that she did desire to retain her implants. On September 30, or October 1, 1974 respondent redid the augmentation mammoplasty on H [REDACTED] B [REDACTED]. Drains were placed in each breast and while the precise time was not established at this hearing, the drains remained in the breasts for approximately seven days on the right side and approximately ten days on the left side.

XIII

During the week following surgery respondent came to the home of H [REDACTED] B [REDACTED] on at least two different occasions and respondent did dress the incision and give postoperative care. At first the incisions appeared to be healing, however, infection

subsequently developed, particularly on the patient's right breast. On October 12, 1974 a family member called respondent on behalf of H [REDACTED] B [REDACTED]. Respondent was advised that H [REDACTED] B [REDACTED] had a fever of 102 degrees; that she was suffering a great deal of pain; that stitches were ripping at the incision site on the right breast and that the implant was exposed. At this time respondent directed that H [REDACTED] B [REDACTED] be hospitalized at the San Vicente Hospital. Respondent came to the hospital where he examined H [REDACTED] B [REDACTED] in her hospital room. He determined that there was an infection and he prescribed antibiotics to be administered intravenously. Respondent removed the stitches on the right breast and following his examination he did indicate to the husband of H [REDACTED] B [REDACTED] that the implants might have to be removed.

XIV

At approximately noon on October 14, 1974 respondent discharged the patient H [REDACTED] B [REDACTED] from the San Vicente Hospital by telephone. Respondent had not examined this patient on October 14, 1974 the date of her discharge nor did he discuss with H [REDACTED] B [REDACTED] the fact that she would be discharged from the hospital. At the time of her discharge the wound on her right breast was still open and the implant was exposed and draining pus. The left breast was rather hard and did show some evidence of hematoma. The patient H [REDACTED] B [REDACTED] was in pain at the time of her discharge. She was shocked and depressed when she was told that she would be discharged. Ms. B [REDACTED] contacted her husband and within two hours she was placed under the care of another physician.

XV

Sometime early in September 1974 T [REDACTED] K [REDACTED] H [REDACTED] contacted the organization of Women Who Help Women. In due course Ms. H [REDACTED] contacted respondent on or about September 7, 1974. Ms. H [REDACTED] who is approximately five feet five inches in height and weighs between 100 and 105 pounds indicated to respondent that she desired small implants and respondent advised her that there would be no problem. Ms. H [REDACTED] also advised respondent concerning her health history, specifically that she was hypoglycemic and that she was allergic to Xylocaine and Novocain. She was advised to not eat for one day prior to surgery and surgery was scheduled for September 11 at Stanton. When she arrived at Stanton she was given an injection and she was asked for \$25.00 for a blood test. Ms. H [REDACTED] did not have the \$25.00 but evidently she was given a blood test. She received no other physical examination prior to her surgery. Thereafter, respondent did perform an augmentation mammoplasty; however, the inserts were much larger than the patient had expected. She was concerned about

the size of her breasts but respondent reassured her that everything would be all right. T K H did develop a large area of discoloration particularly on her left arm and left side. On or about September 17, 1974 a second procedure was performed on T K H to remove a blood clot from her left breast. At this second procedure respondent was present and also Dr. Brown. Following the second surgery the right breast developed a capsule and the left breast lowered. On or about November 4, 1974 respondent performed a third operation on T K H to release the capsule in her left breast and to raise the right breast. Following this surgery the left breast again hardened and it was substantially larger than the right breast. T K H continued to complain about the large size of her breast, however, she advised the respondent to leave the right breast as it was and to operate further on the left breast to make it equal in size to the right breast.

XVI

The patient T K H went to respondent's surgical clinic very late on the evening of January 14, 1975. There was no one present at that time who could administer a general anesthetic to the patient. Respondent attempted the procedure by the use of local anesthetics. However, these local anesthetics did not have the desired results on T K H. Respondent did perform this fourth surgery in an effort to make the left breast equal in size to the right breast. The patient did complain a great deal and she did suffer considerable discomfort during the surgery.

XVII

Following the fourth surgery the implant on the left breast of T K H fell and respondent advised T K H that a further procedure would have to be done on the left breast to raise it to the level of the right breast. Ms. H indicated that she did not wish to have any further surgeries unless she was appropriately anesthetized. Respondent did advise Ms. H that an anesthetist would be present but she would have to pay \$50.00 for this service. Thereafter on March 14, 1975 T K H again returned to respondent's clinic believing that her left breast would be raised to the same level as her right breast. The procedure actually performed by respondent, however, was the removal of both implants and the insertion of different shaped implants into the patient's breasts. The last set of implants enlarged T H breasts so that she was unable to extend her arms forward without her arms touching the outside of her breasts. She observed that her nipples pointed outward and their location was not appealing. A further result of the surgeries was a loss of considerable feeling in both breasts. At the present time T K H has very little feeling in either breast and she has since had further surgery to remove the implants in her breasts.

XVIII

On or about March 5, 1976 respondent performed an augmentation mammoplasty on patient C [REDACTED] L [REDACTED]. Thereafter respondent administered postoperative care, the stitches were removed and Ms. L [REDACTED] was told to return for continuing postoperative observation. Early in April 1976 Ms. L [REDACTED] developed infections in both breasts. Thereafter, respondent saw the patient more often, he cleaned the breasts with water and peroxide and prescribed some powder which the patient was to apply to her breasts.

XIX

On June 8 or 9, 1976 respondent performed a second operation on C [REDACTED] L [REDACTED] to release the capsules in both breasts. The patient was informed by respondent that he drained blood and pus from the incisions during the surgery. Respondent did place a drain in the patient's left breast and this drain was left in for approximately one week. Postoperative care was continued and on July 9 it was determined that the right breast was hardening and possibly infected. On or about July 16, 1976 C [REDACTED] L [REDACTED] was advised by respondent that she would require a third surgery in order to correct the hardening in her right breast. Respondent performed a third surgery on Ms. L [REDACTED] on July 27, 1976 to release the capsule in her right breast. Postoperative care continued and by August 20 the incision appeared to be healing. As time went on, however, an infection again developed in the right breast of C [REDACTED] L [REDACTED]. By September 18 Ms. L [REDACTED] right breast was painful and became discolored in the area of the incision. On September 20, 1976 the silicone implant in the right breast of C [REDACTED] L [REDACTED] broke and some of the silicone material spilled out. C [REDACTED] L [REDACTED] went to respondent's office but respondent was not there. One of respondent's employees did contact respondent by telephone and respondent was advised that the incision had opened and the implant was being held in the breast by a small amount of skin. Respondent suggested that his employee cut the skin and remove the implant; however, the employee was reluctant to take this action. Later that evening respondent returned to his office where respondent snipped the skin holding the implant in her right breast, he pressed from the top of the right breast and forced the implant out of the breast. Respondent did perform this procedure while he was in his street clothes and in a non-sterile setting. He did, however, wash his hands prior to removing the implant and he did treat the infected area with some medication.

XX

The patient C [REDACTED] L [REDACTED] did from time to time receive medication to treat infections which developed. On September 22, 1976 respondent advised Ms. L [REDACTED] that she had an infection in her

right breast and he prescribed Chloromycetin. Subsequently on September 30 or October 1 respondent prescribed Erythromycin. Subsequently on October 6, 1976 C██████ L██████ advised one of respondent's employees that the infection still had not cleared up and was still draining. Respondent at that point authorized a telephone prescription for Ampicillin. During the period from October 6 through November 2, 1976 C██████ L██████ did on various occasions contact one of respondent's employees by telephone. As a result of these contacts C██████ L██████ did receive Ampicillin, Chloromycetin and Vibramycin. It was not established, however, that this employee was prescribing any medication without respondent's prior direction. Respondent failed to take a blood smear of the patient C██████ L██████ until sometime after he first prescribed Chloromycetin for the patient. The patient C██████ L██████ became increasingly concerned about the failure of her infection to clear up. She last saw respondent on or about November 3, 1976. She declined to submit to any further surgical procedures and a day or so later she sought advice from another physician. C██████ L██████ was diagnosed as having a serious infection. She was hospitalized a short time later, a blood smear was taken and the infection was cleared up.

XXI

On or about July 17, 1976 a patient A██████ K██████ contracted with respondent for the performance of an abdominal lipectomy and a tubal ligation. On August 3, 1976 these procedures were performed upon that patient by respondent at his medical clinic on Wilshire Boulevard, known as Wilshire Surgical Clinic. Following the surgery an employee of respondent drove A██████ K██████ to her home. A██████ K██████ was scheduled to return to respondent's office on August 6, 1976 for postoperative care. She was informed that a car maintained by respondent would be sent to her residence to take her to the office. On August 5 the driver did not come to the residence of A██████ K██████. On the following day, August 6 the mother of A██████ K██████ took Ms. K██████ to respondent's medical clinic. Ms. K██████ was examined by an individual who she described as a youthful Latin with curly hair. This individual introduced himself to Ms. K██████ as a doctor and stated that he assisted respondent in the operation of Ms. K██████. The Latin removed the bandages and commented that Ms. K██████ stomach looked beautiful. A foul odor and drainage was noted as coming from the incision. Ms. K██████ complained about a great deal of pain. The Latin advised Ms. K██████ to continue with the medication which she had been given. He bandaged the incision and told Ms. K██████ that he had applied a pressure bandage and that it must be removed in three days. On August 7 and 8, 1976 A██████ K██████ suffered extreme pain at the site of the abdominal incision. She and her mother repeatedly attempted to contact respondent but respondent

was unavailable. On August 9, 1976 the date Ms. K [REDACTED] was scheduled to see respondent she was advised in a telephone conversation that the driver who was supposed to bring her into the office on that day was unable to pick her up. This individual advised Ms. K [REDACTED] that she had spoken with respondent and Ms. K [REDACTED] was to pull down her bandages and everything would be all right. Thereafter, on August 10 and on August 11 Ms. K [REDACTED] made repeated phone calls to respondent's office stating that she must be seen but she was advised by respondent's employees that respondent was unavailable. She was reassured that things would be all right. On August 11, 1976 A [REDACTED] K [REDACTED] was admitted to the emergency department of Kaiser Hospital in Harbor City. At that time she had a severe wound infection and massive abdominal wall cellulitis. A [REDACTED] K [REDACTED] has been left with a somewhat irregular scar. The scar is lower on one side than on the other. The shortcomings, however, are not extreme. Following the surgery she experienced numbness over the right lateral cutaneous nerve of the thigh.

XXII

An organization known as Women's Advisory Council was originally located in Inglewood, California and thereafter relocated to offices at 1137 Second Street, Santa Monica, California. Vicki Amar, the wife of respondent, was one of the principals in this organization. Commencing at approximately June 1976, one Maurice Barbakow also known as Maury Barr became a principal in Women's Advisory Council. Actually Mr. Barbakow became the directing force behind the organization. A primary purpose of this organization was to advertise cosmetic surgery in the radio and press, to sell surgical procedures to individuals interested, collect adequate funds from the individuals and then to arrange for surgeons to perform the requested procedures. Respondent did perform many surgeries for individuals who had initially come to Women's Advisory Council. Other physicians were also employed by this organization to perform surgical services.

It became a rather common practice to prescribe certain drugs for patients to take commencing approximately five days prior to their scheduled surgery. Maurice Barbakow and Vicki Amar arranged with Lifetime Pharmacy to have these patients provided with the required medications. The pharmacist in each case would make a call and a prescription would be prepared and the medication would be issued to the patients as follows:

A. On or about November 30, 1976 at the business premises of the Women's Advisory Council located at 1137 Second Street, Santa Monica, California Maurice Barbakow furnished to E [REDACTED] S [REDACTED] through Lifetime Pharmacy certain dangerous drugs namely Ampicillin, Ananase, and Synkayvite and again on December 10, 1976 Mr. Barbakow

arranged for E████ S████ to again obtain these same drugs through Lifetime Pharmacy. Lifetime Pharmacy issued the medication and in each case respondent's name appeared on the containers as the prescribing physician.

B. On or about January 10, 1977 at the premises of Women's Advisory Council an individual who could not be identified at this hearing did arrange for L████ B████ to obtain certain dangerous drugs namely Ampicillin, Ananase and Synkayvite through Lifetime Pharmacy. Lifetime Pharmacy issued the medication and in each case respondent's name appeared on the containers as the prescribing physician.

C. On or about December 18, 1976 at the premises of Women's Advisory Council Maurice Barbakow arranged to have P████ M████ obtain certain dangerous drugs namely Ampicillin Ananase, and Synkayvite through Lifetime Pharmacy. Lifetime Pharmacy issued the medication and in each case respondent's name appeared on the containers as the prescribing physician.

D. On or about January 11, 1977 at the premises of Women's Advisory Council an employee of the council arranged for B████ T████ to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. Lifetime Pharmacy issued the medication and in each case respondent's name appeared on the containers as the prescribing physician.

E. On or about January 11, 1977 at the premises of Women's Advisory Council Maurice Barbakow arranged for M████ H████ to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. Lifetime Pharmacy issued the medication and in each case respondent's name appeared on the containers as the prescribing physician.

F. On or about November 5, 1976 at the premises of Women's Advisory Council Maurice Barbakow arranged for J████ P████ to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. Lifetime Pharmacy issued the medication and in each case respondent's name appeared on the containers as the prescribing physician.

G. On or about November 26, 1976 at the premises of Women's Advisory Council Maurice Barbakow arranged for J████ D████ C████ to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. Lifetime Pharmacy issued the medication and in each case respondent's name appeared on the containers as the prescribing physician.

Respondent did not conduct any physical examination with respect to any of the above listed patients prior to the time that they received the Ampicillin, Ananase or Synkayvite.

Maurice Barbakow, also known as Maury Barr, did not hold any license issued by any healing arts board which would authorize him to furnish or prescribe dangerous drugs. No employee of Women's Advisory Council who arranged for individuals to obtain dangerous drugs was ever the holder of any license issued by any healing arts board which would authorize such individual to prescribe dangerous drugs. However, it was not established that respondent ever authorized Maurice Barbakow or any employee of Women's Advisory Council to prescribe drugs for individuals. A spokesman for Women's Advisory Council would send the individual to the pharmacy and the pharmacy would prepare the prescription.

XXIII

During 1976 and continuing thereafter until the time of the hearing in January 1978 respondent maintained a clinic and medical offices at 6399 Wilshire Boulevard, Los Angeles, California. The building directory at that location identified respondent's business office and clinic as "Wilshire Cosmeutic Surgical Clinic". The door to respondent's medical offices identify his practice as "Wilshire Surgical Clinic, Cosmetic and Gynecology".

During 1976 and 1977 respondent did maintain business cards at his place of business 6399 Wilshire Boulevard, Los Angeles, California. Respondent during this period of time did present business cards to various patients. The business cards bore the legend "Wilshire Surgical Clinic". At least one individual received a business card of respondent at the premises of Women's Advisory Council and from an employee of that organization. Respondent's business card bore the legend "Wilshire Surgical Clinic".

On or about April 7, 1976 respondent caused the June 1976 issue of the Pacific Telephone White Pages Directory for the Los Angeles Exchange, Central Section of the Los Angeles extended area to contain the following listing "Wilshire Cosmetic Group, 6399 Wilshire Bl 655-6945." In the same directory respondent also caused the following listing to appear. "Wilshire Surgical Clinic 6399 Wilshire Bl 655-6945".

In the August 1976 issue of the Pacific Telephone Yellow Page Directory for the Los Angeles Exchange, Central Section of the Los Angeles extended area respondent caused the following entry to appear.

"Amar Leroy J

Member American Medical Association
Wilshire Surgical Clinic
Cosmetic & Gynecological Surgery
Day or Night Call
6399 Wilshire BL 655-6945"

In the same issue of the same directory respondent caused the following listing to appear.

"WILSHIRE SURGICAL CLINIC
Leroy's Amar M.D.
Member American Medical Association
Cosmetic & Gynecological Surgery
Day or Night Call
6399 Wilshire BL 655-6945"

At no time during the period commencing 1976 through 1977 did respondent have a valid permit issued by the Division of Licensing whereby respondent was registered or authorized to use the fictitious names of "Wilshire Cosmetic Surgical Clinic," "Wilshire Surgical Clinic, Cosmetic and Gynecology," "Wilshire Surgical Clinic," or "Wilshire Cosmetic Group" and each of the above-described fictitious names was used in connection with the medical practice of respondent during the period commencing 1976 through 1977.

XXIV

The business enterprise known as Women's Advisory Council was directed and managed in part by respondent's wife, Vicki Amar and also Maurice Barbakow. Maurice Barbakow was the more dominant individual in this business enterprise. The Women's Advisory Council caused advertisements to be placed and published in the Los Angeles Times, a newspaper of general circulation. The advertisements offered to women a "No fee" consultation concerning "Facelifts" and other forms of plastic and cosmetic surgery. The ads further stated that financing for the cost of surgical procedures would be available and the ads as well as the name of the organization itself conveyed the impression that Women's Advisory Council was an organization with particular concern and sensitivity for women as a class. Individuals including El S, L, B, P, M, B, T, M, H, J, P and J D C, each responded to advertisements placed by Women's Advisory Council and each paid various sums or gave items of value either to Women's Advisory Council or to Maurice Barbakow or to Vicki Amar who was also known as Vicki Barbakow and these sums or items of

value were paid to Women's Advisory Council or its principals as a deposit toward or in full payment for certain promised cosmetic surgical procedures. With respect to M█████ H█████ and J█████ P█████, respondent did perform the requested surgical procedures. With respect to E█████ S█████, L█████ B█████, P█████ M█████, B█████ T█████ and J█████ D█████ C█████, respondent did not perform any surgical procedures.

While indeed there was a continuing business relationship between Women's Advisory Council and respondent it was not established that Women's Advisory Council was an organization controlled by respondent, nor was it established that Vicki Amar, also known as Vicki Barbakow or Maurice Barbakow, also known as Maury Barr, were ever agents or employees of respondent with respect to the operation of Women's Advisory Council. While it is true that respondent did perform surgical procedures on several individuals who came to Women's Advisory Council, it is also quite true that this organization referred patients to several other surgeons active in the cosmetic field. Actually, a great deal of hostility often existed between respondent and Maurice Barbakow as well as between respondent and Vicki Amar. Respondent did not pay for the advertising of Women's Advisory Council and he exercised no control over that organization.

XXV

Respondent was born in Louisiana where he received his early education. He attended Southern University but he received no degree from that institution. He served in the United States Army and part of this service was in the intelligence section. Following his discharge he returned to college and he received his Bachelor's degree in June 1959 from Tennessee State. Respondent commenced his medical education at Maherry Medical School in 1956. He did experience some academic difficulties. He left that institution and obtained his Bachelor's degree at Tennessee. He then returned to Maherry Medical College from 1959 through 1961 for personal reasons involving his marriage and pending divorce and attended Howard Medical School commencing in September 1961 until June 1963. Respondent received his medical degree from Howard University. Respondent interned at Freedman's Hospital during 1963 and 1964. He next went to Harlem Hospital in New York where he obtained a residency in obstetrics and gynecology. This was a surgical residency and a portion of his training was in general surgery. It was also during this period when respondent did assist in some breast surgeries. Respondent was admitted to practice medicine in the States of New York and Maryland.

Respondent came to California in 1966 and he was licensed to practice medicine in this state in May of that year. He was first employed by California Lutheran Hospital where he became chief of obstetrics and gynecology. In June 1967 respondent took the examination for Board certification in obstetrics and gynecology. Unfortunately, respondent failed this examination. Respondent has served in various hospitals in the Los Angeles area where he has worked largely in obstetrics and gynecology and he has also seen considerable service for various hospitals in the emergency room. Respondent became the director of the Hope Emergency Clinic in 1971 and also the Wall Street Medical Clinic. Later respondent became associated with Manchester Hospital and with University Hospital. It was during this period that respondent first met Mr. Dubin who at that time operated an ambulance service.

In 1974 respondent again met Mr. Dubin. By this time Mr. Dubin and his wife had founded an organization known as "Women Who Help Women." This organization did advertise and the advertisements were directed to women who would desire to obtain abortions. Respondent agreed to work for Women Who Help Women approximately one day a week, and he initially performed abortions on patients which were obtained by the organization known as Women Who Help Women. Sometime in June or July 1974 the organization entered the field of cosmetic surgery and a Dr. John Brown was engaged to perform these procedures. Respondent wished to receive instruction in the field of plastic surgery and ultimately the officers of Women Who Help Women persuaded Dr. Brown to instruct respondent in this field. Dr. Brown was quite unhappy with the arrangement because he was also required to pay respondent \$1,000.00 a week which sum could otherwise be retained by Dr. Brown. Dr. Brown did not feel that respondent should be paid this fee while he was being instructed. Thereafter, for the most part respondent relied upon Dr. Brown for his instruction. He also assumed that Dr. Brown would require any pre-operative tests he deemed necessary and conduct any pre-operative physical examination. As time went on respondent undertook a few breast augmentation cases under the immediate direction of Dr. Brown. Respondent continued his instruction into other areas of plastic surgery and in the meantime he was attending various seminars conducted in the field of plastic surgery.

XXVI

Respondent opened his surgical clinic, Wilshire Surgical Center, late in 1974. In 1975 respondent was one of a group who purchased Manchester Community Hospital and renamed it Robert F.

Kennedy Community Hospital. Respondent worked in the emergency room of Kennedy Hospital. There were other individuals who gave some services to the hospital evidently on a volunteer basis and at this time respondent met Mr. Maurice Barbakow who worked at the facility in some administrative capacity and he also worked on behalf of the Wilshire Surgical Clinic. The Robert F. Kennedy Community Hospital closed in December 1975. The financial problem of this facility was in part due to the fact that for some reason the hospital was not eligible to receive Medi-Cal payment from the State of California.

XXVII

Sometime in 1975 Henry Dubin formed the National Health and Appearance Foundation and Vicki Amar, respondent's wife, also founded the Women's Advisory Council. The funds needed to start Women's Advisory Council evidently came from the mother of Mrs. Amar. Maurice Barbakow became quite active in both the National Health and Appearance Foundation and also the Women's Advisory Council. It is quite true that these organizations did refer some patients to respondent for cosmetic surgery, however, at this time respondent did not control these organizations. Maurice Barbakow had previously suffered some form of criminal conviction for dishonest conduct. In approximately March 1976 he was rearrested. By this time respondent's wife had become emotionally involved with Maurice Barbakow. She persuaded respondent to engage counsel and to obtain Mr. Barbakow's release pending trial. At about this point in time Vicki Amar moved in with Maurice Barbakow and she began using the name Vicki Barbakow. Respondent became involved with a young lady who had for sometime been both an employee and social companion. Respondent and this young woman resided at the Wilshire Surgical Clinic. In approximately July 1976 the National Health and Appearance Foundation was in serious financial trouble. Respondent took this organization over but business records were virtually non-existent. Respondent closed the office of the National Health and Appearance Foundation and had the telephone transferred to the Wilshire Surgical Clinic. Respondent's girl friend was assigned to this telephone and when calls were received she attempted to determine what surgery was promised, what amount was due and she would then consult with respondent to determine whether or not respondent might undertake this surgery.

XXVIII

Women's Advisory Council also experienced serious problems. Maurice Barbakow left the state apparently to face federal criminal charges. Vicki Amar suffered emotional problems and was hospitalized on various occasions. Again the business records of Women's Advisory Council were inadequate and outraged

patients were threatening both civil and criminal action against Vicki Amar. After a great deal of consultation respondent agreed to perform numerous surgical procedures for persons who had paid sums to Women's Advisory Council. Women's Advisory Council ceased doing business early in 1977.

XXIX

Respondent has regularly attended seminars and continuing education programs in the field of cosmetic surgery for the past several years. He has attended programs presented by various California medical schools and various other educational programs conducted throughout the United States. He also attended a two week course in Brazil. Respondent does recognize that he is not qualified in all phases of cosmetic surgery and he feels that in part because of his race he did not have an opportunity to obtain a residency in plastic surgery.

XXX

As to the patient B██████ B██████, respondent does point out that this was Dr. Brown's patient. Respondent was not consulted with respect to the number of procedures which were performed. Respondent was at all times under the direction of Dr. Brown.

The patient M██████ S██████ was also the patient of Dr. Brown. Respondent was an employee of the organization known as Women Who Help Women but at that time he was not employed as a surgeon or treating physician in the area of cosmetic surgery. M██████ S██████ efforts to contact respondent evidently were unknown to respondent.

Regarding L██████ S██████, respondent simply assumed that Dr. Brown had examined that patient prior to surgery and he notes that she received her doctor's permission to undergo this surgery. Respondent strongly denies that he would ever subject a patient to severe pain. Obviously any surgical procedure will cause concern to the patient but respondent does refer to his medical records which would indicate that the patient was appropriately sedated. Respondent does realize that one of Ms. S██████'s ears was not placed in the proper position. He does not feel that this establishes incompetence however, and he did offer to redo that ear without further cost to the patient. However, the patient declined any further procedures.

Concerning the patient H█████ B█████, it is respondent's position that he did not leave drains in the breasts for seven or ten days. However, he does not know the precise time that drains were left in the breast. When the infections developed respondent did feel that it would be necessary to remove the implants in order to treat the infection. In his judgment, however, he felt that H█████ B█████ was quite emotional and she would become seriously upset if respondent attempted to remove the implants. As to respondent discharging the patient, it is his position that the patient's temperature had gone down to normal and respondent contends that it was the patient's mother who wished to take the patient out of the hospital. Even assuming that the mother wished to take H█████ B█████ from the hospital respondent was still under a duty to examine the patient and to decide if it was medically appropriate to discharge the patient.

Concerning the patient T█████ K█████ H█████, it is respondent's position that this patient never complained concerning the size of her breasts. He does concede that there were several surgeries. However, they were not all performed in order to obtain equal size and proper placement of the breasts. Respondent also contends that the surgeries did not leave multiple scars on this patient and all entries were made essentially through the same incision. Again respondent strongly denies that he would ever proceed with a surgery if the patient is suffering.

As to the patient C█████ L█████, it is respondent's position his medical records show that this patient did not have a draining infection for a period of three months and actually many of the visits did indicate that the infection was clearing up. Respondent denies that he would perform surgical procedures through infected wounds. Concerning the prescriptions of Chloromycetin, it is respondent's position that he gave a minimum prescription of this drug to the patient, which would not subject her to any appreciable risk. He feels that this drug is more commonly prescribed in other sections of the country and the world. Respondent did not permit his assistants to prescribe drugs. Blood tests of this patient were in fact taken; however, none prior to the time that Chloromycetin was prescribed.

Concerning the patient A█████ K█████, it is respondent's position that the surgery was in fact a good one and the scar while perhaps not perfect is not as bad as it is

described in this accusation. Respondent never told this patient that stretch marks above the navel would be removed and he is at a loss to understand how the patient received this impression. Finally, respondent contends that he did not abandon this patient. He points out that he did see the patient three or four days after the surgery when the patient was brought in to his office by the patient's mother. He was personally unaware that his driver had some difficulty in picking up Ms. K [REDACTED] for her office appointment.

With respect to the balance of the charges, respondent contends that many of his problems were caused by Mr. Maurice Barbakow, an individual who took advantage of respondent in every particular. Mr. Barbakow apparently stole money from respondent and from other organizations such as the Women's Advisory Council. He would make extensive promises to clients in order to obtain funds and then he failed to pay these funds over to respondent or other surgeons for work which they performed. It is respondent's position that he did not control any of the organizations including Women Who Help Women, the National Health and Appearance Foundation or the Women's Advisory Council. Actually these organizations retained several physicians from time to time to perform cosmetic surgery. Respondent was simply one of the physicians that would be retained. Actually respondent feels that he was of considerable assistance to many women who had paid money to these organizations but would not have received any surgery unless respondent had agreed to perform these surgeries for little or no compensation. Finally, it is respondent's position that he did consult with other cosmetic surgeons and he did confer with these individuals in many instances.

DETERMINATION OF ISSUES

I

Under the provisions of Sections 2360 and 2361 of the Business and Professions Code the Division of Medical Quality

has the authority to impose appropriate discipline where any licensee has committed acts or has been guilty of omissions which constitute grounds for disciplinary action.

A. Patient Ms. B [REDACTED]:

Respondent did not perform any of the surgical procedures on Ms. B [REDACTED]. Respondent was guilty of negligence where he raised no objection or at least made no inquiry concerning the simultaneous performance of four plastic surgical procedures. However, it was not established that such conduct amounted to gross negligence or gross incompetence.

B. Patient M [REDACTED] S [REDACTED]:

Again respondent did not perform the surgery on this patient. As assisting surgeon, however, he was negligent to some degree concerning pre-operative records, but his conduct in this instance did not amount to gross negligence or gross incompetence.

C. Patient L [REDACTED] S [REDACTED]:

Respondent was guilty of gross negligence and gross incompetence in proceeding with two life threatening operations on this patient without conducting a careful prior medical examination. To operate on this patient who had a sunken chest causing her breasts to gravitate to the center of the chest was gross incompetence. The fact that the autoplasty performed by respondent on the patient's left ear failed to substantially alter the position of that ear may demonstrate some degree of incompetence or negligence but not gross incompetence or gross negligence.

D. Patient H [REDACTED] B [REDACTED]:

Respondent was negligent and incompetent in leaving the breast implants in place after a serious infection developed. However, respondent's actions in this regard do not amount to either gross incompetence or gross negligence. Respondent was guilty of gross negligence and gross incompetence when he discharged H [REDACTED] B [REDACTED] from the hospital by telephone order at a time when she had an open wound in her right breast and an exposed implant. Even assuming that the mother of this patient desired her release from the hospital respondent had the compelling obligation to make a careful examination of this patient and to determine for himself whether it was appropriate to discharge her.

E. Patient T [REDACTED] K [REDACTED] H [REDACTED]

It was not established that respondent was guilty of gross incompetence or gross negligence with respect to the insertion of implants. It was not established that these implants were successively larger. Respondent was guilty of gross incompetence by virtue of the number of procedures that he was required to perform in order to obtain equal size and proper placement of the implants. It was not established that the patient was left with extensive scars by virtue of the multiple procedures. Respondent was guilty of gross negligence in performing the fourth surgery without appropriate anesthesia. Respondent may have believed that the patient was properly sedated but he certainly owed his patient the obligation of paying more attention to her complaints and insuring that she was comfortable during the procedure.

F. Patient C [REDACTED] L [REDACTED]

This patient did develop a serious infection. The failure to remove the implants as part of the treatment of the serious infection constitutes both gross negligence and gross incompetence. Respondent was not guilty of gross negligence or incompetence by virtue of his removal of this implant from his patient. Respondent did in fact wash his hands before removing the implant and the wound was treated immediately following the removal of the implant. It was not established that respondent permitted his assistant to prescribe antibiotics for this patient. Respondent was consulted and he did issue all of the prescriptions for this patient.

G. Patient A [REDACTED] K [REDACTED]

Respondent was guilty of some degree of negligence and incompetence with respect to the location of the scar on this patient. This action, however, did not amount to gross negligence or that degree of incompetence which is required for disciplinary action. Respondent is not subject to disciplinary action for his failure to remove certain stretch marks. The stretch marks complained of by this patient could not be removed by the procedure performed by respondent. The problem here is not a case of negligence or incompetence but simply a misunderstanding between the patient and the physician. Respondent has been guilty of gross negligence in that A [REDACTED] K [REDACTED] was unable to contact respondent and to obtain promised treatment from respondent at a time when she was in serious need of respondent's care. Respondent promised this patient that he would provide transportation to his office for postoperative care. The patient relied on that promise and respondent was obligated to meet his commitment. The fact that respondent may not have

been fully aware of this patient's problems is not persuasive. Respondent did know that he had operated on this patient and he was fully aware that she would require postoperative care. He had an obligation to be available should she have problems and respondent's conduct in this instance did amount to an abandonment of his patient.

II

As set forth above, respondent has been guilty of gross negligence, of incompetence and of gross incompetence and by each such action he has subjected his license to disciplinary action pursuant to the provisions of Sections 2361(b) and (d) of the Business and Professions Code.

III

It was not established that respondent violated Section 2399.5 of the Business and Professions Code in connection with the prescriptions received by the patients mentioned in Findings XXII.

IV

It was not established that respondent was guilty of aiding and abetting his office assistant in the unlawful practice of medicine within the meaning of Section 2141 of the Business and Professions Code.

V

In reference to the prescriptions obtained by clients of Women's Advisory Council, it was not established that respondent assisted in or abetted in the unlicensed practice of medicine by Maurice Barbakow or any other employee of Women's Advisory Council.

VI

Respondent did use a fictitious name and at the time of such use he did not hold a permit for such use issued by the Division of Licensing. By such conduct respondent did violate Section 2393 of the Business and Professions Code and he has subjected his license to disciplinary action. But this separate offense, standing alone, would not be a basis for the revocation penalty imposed in this case.

VII

This respondent was certainly closely associated with individuals who operated the Women's Advisory Council and similar

organizations. It was not established, however, that respondent employed cappers or steerers or other persons in attempting to procure patients for his medical practice. Under these circumstances respondent is not subject to disciplinary action pursuant to the provisions of Section 2399 of the Business and Professions Code.

VIII

The facts established by respondent have been considered in making the order herein set forth. While it is true that some of respondent's problems may have been created or compounded by others this respondent has engaged in most serious misconduct. While respondent does possess many admirable qualities, he has in many instances failed to exercise wisdom or prudence.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. C28142 issued to respondent Leroy Amar, M.D. is revoked pursuant to Determination of Issues I-C, I-D, I-E, I-F, and I-G, in conjunction with II, separately and for all of them.

This decision shall become effective on February 2, 1979

SO ORDERED January 3, 1979

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

By Michael J. Carella
Michael J. Carella, Ph.D.
Secretary-Treasurer

FL:jw

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

REDACTED

In the Matter of the Accusation)
Against:)
LEROY AMAR, M.D.)
Respondent.)

NO. D-1977

L-14064

NOTICE OF NON-ADOPTION OF PROPOSED DECISION

(Pursuant to Section 11517 of the Government Code)

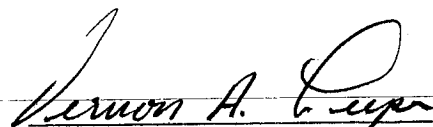
TO THE RESPONDENT ABOVE NAMED:

YOU ARE HEREBY NOTIFIED ~~that~~ the Division of Medical Quality of the Board of Medical Quality Assurance of the State of California has decided not to adopt the attached proposed decision, filed herein by the duly assigned Administrative Law Judge, John A. Willd, and dated March 16, 1978. You are also notified that the Division of Medical Quality will decide the case upon the record, including the transcript and without the taking of additional evidence. You are hereby afforded the opportunity to present written argument to the Division of Medical Quality, if you desire to do so, by filing such written argument with the Division at its office at 1430 Howe Avenue, Sacramento, California, 95825, and the same opportunity is afforded the Attorney General of the State of California.

You will be notified of the date for submission of such written argument when the transcript of the administrative hearing becomes available.

DATED: May 4, 1978

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE


VERNON A. LEEPER, Program Manager
Enforcement Unit

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation)	
Against:)	
)	
LEROY AMAR, M.D.)	NO. D-1977
Physician's and Surgeon's)	
Certificate No. C28142,)	L-14064
)	
Respondent.)	
)	

PROPOSED DECISION

This matter came on regularly for hearing before John A. Willd, Administrative Law Judge with the Office of Administrative Hearings, at Los Angeles, California, on November 2, 1977, at the hour of 9:00 a.m. Dora Levin and Gayle M. Askren, Deputies Attorney General, appeared on behalf of the complainant, and at least one of the deputies was present at all times during the proceedings. The respondent, Leroy Amar, M.D., was personally present at all times during the proceedings and for a portion of the time he was represented by Henry Lewin, his attorney. This matter was heard on November 2, 3, 4, 7, 8, 9, 10, 14, and 15, 1977. The matter was again heard on January 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, and 20, 1978. Mr. Henry Lewin represented the respondent at all stages of the proceedings until January 4, 1978. On that date the respondent Leroy Amar substituted himself as counsel in this matter and Mr. Henry Lewin was relieved as counsel based upon the motion personally made by respondent. Thereafter, the respondent proceeded in propria persona although Mr. Henry Lewin did remain with respondent and did consult with him through January 6, 1978. Evidence both oral and documentary having been received, the matter was submitted and the Administrative Law Judge makes the following findings of fact:

I

Joseph P. Cosentino, M.D. filed the Accusation and the First Supplemental Accusation herein in his capacity as the Acting Executive Director of the Board of Medical Quality Assurance.

II

On or about June 10, 1966 respondent Leroy Amar, M.D. was issued physician's and surgeon's certificate No. C28142 by the

Board of Medical Examiners, the predecessor agency to the Board of Medical Quality Assurance. Said certificate is now and was at all times mentioned herein in full force and effect.

III

Sometime in July 1974 Ms. B████ contacted an organization known as Women Who Help Women. Ms. B████ spoke with a Mr. Dubin who was the principal directing force of the organization. Ms. B████ contracted for the following surgical procedures: Face lift, eyelid lift and repair of a deviated septum. On or about August 27, 1974 Ms. B████ went to a surgical facility at Stanton, California. Shortly after her arrival respondent introduced himself to Ms. B████ and he took some pre-operative photographs of her. Later respondent was present in the operating room and had a brief discussion with Ms. B████ concerning anesthetics she would receive. Respondent did not perform any surgical procedures on Ms. B████. The surgical procedures of face lift augmentation mammoplasty, eyelid lift and a surgical procedure on the nose of Ms. B████ were all performed by a Dr. Brown. Sometime later Ms. B████ did see Dr. Amar for postoperative care. She complained that something in one of her breasts had slipped and that she was unable to close her eyes. Respondent removed stitches and gave Ms. B████ some medication. Respondent did express his opinion to Ms. B████ that her breast implant was just settling in and that she would be able to close her eyes in time. The surgical result for Ms. B████ were not favorable. For several months following surgery she had a bad smell emanating from within her nose. The tip of her nose would turn blue and red particularly in cold weather. Her left breast has become very hard and she was unable to close her eyes for approximately six months following surgery. In addition she has very limited movement of her right eyebrow.

IV

In or about August 1974 M████ S████ contacted the organization known as Women Who Help Women and made inquiry about a breast lift. She spoke with Mr. Henry Dubin of that organization and she was assured that it was a rather simple procedure which they performed all of the time. On one visit to the offices of Women Who Help Women her breasts were examined by Dr. John Brown and she was observed by respondent. On August 31, 1974 M████ S████ went to the medical facility at Stanton, California. She received no physical examination prior to surgery. She put on a gown which was provided for her and walked into the surgery room. Dr. Brown and the respondent were both in the operating room and respondent was introduced to M████ S████ as the assistant surgeon. Thereafter the patient was anesthetized and Dr. Brown performed breast surgery on M████ S████. Several days later M████ S████ returned to the offices of Women Who Help Women and her stitches were removed by Dr. Brown. The patient complained that her breast were very sore but she was reassured that there were no problems. The patient was not given any medication.

V

On or about September 11, 1974 the patient M. S. developed an abscess in her left breast. She attempted to reach Dr. Brown but she was advised that he was in San Francisco. She attempted to reach the respondent and she was advised that Dr. Amar would return her call. This patient was not contacted by Dr. Amar. Shortly thereafter her infection ruptured and pus drained from the rupture. This patient went to another physician in order to take care of the infection. This patient was left with deformed breasts. They were uneven in size and became quite hard. Thus far she has received four surgeries in order to correct her condition. Medical records for this patient have never been located. It is not known whether or not medical records were ever prepared or kept for the patient M. S.

VI

In approximately September 1974 L. S. went to the offices of Women Who Help Women. There she spoke with Mr. Dubin and inquired about obtaining breast implants as well as the possibility of modifying her ears so they would lay closer to her head. L. S. also spoke with Dr. John Brown who visually examined her breasts and advised her that she could have breast implants. During this examination L. S. advised Dr. Brown that she did have a heart problem specifically that she had a prolapsed mitral heart valve. Because of this condition L. S. did consult her own physician and inquired whether she might undergo this surgery. Her physician was somewhat cautious but indicated that she might proceed with the surgery.

VII

On September 19, 1974 respondent performed an augmentation mammoplasty and an otoplasty on L. S. Prior to the surgery L. S. did advise respondent that she was suffering from a heart problem. However, respondent did not conduct any physical examination of the patient prior to surgery other than taking a blood test.

VIII

On September 21, 1974 respondent examined L. S. and advised her that corrective surgery would be needed because her right breast was smaller than the left breast. Respondent also attempted to remove stitches in the ear, however, this procedure was quite painful and it was abandoned by respondent.

IX

On September 25, 1974 L. S. again went to the Stanton medical facility. At this point L. S. became most apprehensive concerning further surgery. She told respondent that she was afraid and did not wish to proceed. Respondent reassured

L. S. and told her that there was nothing to this operation, that it would be a breeze. She was given no physical examination but she would from time to time receive a shot of some medication and this medication did tend to calm her. After waiting several hours the patient was ultimately taken into the operating room. L. S. was now very apprehensive. She advised respondent that her heart felt strange, that it was fluttering and that it was bothering her. She asked that someone check her heart and she again indicated that she did not wish to proceed with the surgery. Respondent again reassured L. S. and he told the nurse to proceed with the anesthetic. Respondent did remove the implant in the right breast of L. S. It was not established, however, that he replaced it with one of identical size.

X

L. S. does have a condition which is called pectus excavatum (sunken chest). By virtue of the shape of her chest it is true that there is some tendency for the breasts to gravitate toward the center of her chest, the end result, however, is not in this instance particularly abnormal and the patient is not dissatisfied with the implants from a cosmetic standpoint.

XI

The otoplasty performed by respondent on L. S. was not successful in that while the right ear was placed in a desirable position, the left ear was for some reason not substantially altered when compared to its pre-operative location.

XII

Sometime in approximately September 1974 H. B. went to the office of Women Who Help Women. There she spoke to one Kathleen Dubin and she told Mrs. Dubin that she was considering breast augmentation. Kathleen Dubin advised H. B. that the operation was a simple one which would take approximately forty-five minutes and there would be no discomfort. Mrs. Dubin stated that H. B. would be able to return to work in two or three days and there would be only a hairline scar following the operation. Later, Dr. Brown visually examined H. B.'s breast. Dr. Brown told H. B. that he would be assisted by Dr. Amar. H. B. then left the offices of Women Who Help Women and after discussing the matter with her husband she decided to have the surgery. Surgery for H. B. was scheduled for September 24, 1974 at Stanton, California. H. B. resides with her husband in San Fernando Valley. She decided for her own convenience to stay with her parents on the night of September 23 because her parents live in Orange County near the City of Stanton. On the evening of September 23, 1974 Ms. B. was contacted by a representative of Women Who Help Women by telephone. Ms. B. was advised that Dr. Brown was in San Francisco and would be unable to perform the operation on the following day. Ms. B. was directed to go to a

medical facility in Reseda on the following morning and that a Dr. Berez would perform the augmentation mammoplasty. Dr. Berez did perform the surgery and four or five days later H. B. went to the offices of Women Who Help Women for postoperative care. At this point she was seen by respondent. The surgery performed by Dr. Berez was not satisfactory. The implants were improperly placed; the scar was too large; it was crooked and was too low so that it would be visible below a bra or halter top. Respondent advised Ms. B. that the surgery would have to be redone. There was some discussion concerning the possibility of removing the implants at this point permitting the incision to heal and then redoing the surgery at some future time. Ms. B. did indicate that she did desire to retain her implants. On September 30, or October 1, 1974 respondent redid the augmentation mammoplasty on H. B. Drains were placed in each breast and while the precise time was not established at this hearing, the drains remained in the breasts for approximately seven days on the right side and approximately ten days on the left side.

XIII

During the week following surgery respondent came to the home of H. B. on at least two different occasions and respondent did dress the incision and give postoperative care. At first the incisions appeared to be healing, however, infection subsequently developed, particularly on the patient's right breast. On October 12, 1974 a family member called respondent on behalf of H. B. Respondent was advised that H. B. had a fever of 102 degrees; that she was suffering a great deal of pain; that stitches were ripping at the incision site on the right breast and that the implant was exposed. At this time respondent directed that H. B. be hospitalized at the San Vicente Hospital. Respondent came to the hospital where he examined H. B. in her hospital room. He determined that there was an infection and he prescribed antibiotics to be administered intravenously. Respondent removed the stitches on the right breast and following his examination he did indicate to the husband of H. B. that the implants might have to be removed.

XIV

At approximately noon on October 14, 1974 respondent discharged the patient H. B. from the San Vicente Hospital by telephone. Respondent had not examined this patient on October 14, 1974 the date of her discharge nor did he discuss with H. B. the fact that she would be discharged from the hospital. At the time of her discharge the wound on her right breast was still open and the implant was exposed and draining pus. The left breast was rather hard and did show some evidence of hematoma. The patient H. B. was in pain at the time of her discharge. She was shocked and depressed when she was told that she would be discharged. Ms. B. contacted her husband and within two hours she was placed under the care of another physician.

XV

Sometime early in September 1974 T■■■■ K■■■ H■■■ contacted the organization of Women Who Help Women. In due course Ms. H■■■ contacted respondent on or about September 7, 1974. Ms. H■■■ who is approximately five feet five inches in height and weighs between 100 and 105 pounds indicated to respondent that she desired small implants and respondent advised her that there would be no problem. Ms. H■■■ also advised respondent concerning her health history, specifically that she was hypoglycemic and that she was allergic to Zylocain and Novocain. She was advised to not eat for one day prior to surgery and surgery was scheduled for September 11 at Stanton. When she arrived at Stanton she was given an injection and she was asked for \$25.00 for a blood test. Ms. H■■■ did not have the \$25.00 but evidently she was given a blood test. She received no other physical examination prior to her surgery. Thereafter, respondent did perform an augmentation mammoplasty, however, the inserts were much larger than the patient had expected. She was concerned about the size of her breasts but respondent reassured her that everything would be all right. T■■■■ K■■■ H■■■ did develop a large area of discoloration particularly on her left arm and left side. On or about September 17, 1974 a second procedure was performed on T■■■■ K■■■ H■■■ to remove a blood clot from her left breast. At this second procedure respondent was present and also Dr. Brown. Following the second surgery the right breast developed a capsule and the left breast lowered. On or about November 4, 1974 respondent performed a third operation on T■■■■ K■■■ H■■■ to release the capsule in her left breast and to raise the right breast. Following this surgery the left breast again hardened and it was substantially larger than the right breast. T■■■■ K■■■ H■■■ continued to complain about the large size of her breast, however, she advised the respondent to leave the right breast as it was and to operate further on the left breast to make it equal in size to the right breast.

XVI

The patient T■■■■ K■■■ H■■■ went to respondent's surgical clinic very late on the evening of January 14, 1975. There was no one present at that time who could administer a general anesthetic to the patient. Respondent attempted the procedure by the use of local anesthetics. However, these local anesthetics did not have the desired results on T■■■■ K■■■ H■■■. Respondent did perform this fourth surgery in an effort to make the left breast equal in size to the right breast. The patient did complain a great deal and she did suffer considerable discomfort during the surgery.

XVII

Following the fourth surgery the implant on the left breast of T■■■■ K■■■ H■■■ fell and respondent advised T■■■■ K■■■ H■■■ that a further procedure would have to be done on the left breast to raise it to the level of the right breast. Ms. H■■■ indicated that she did not wish to have any further surgeries unless she was appropriately anesthetized. Respondent did advise Ms. H■■■ that an anesthetist would be present but she would have to pay \$50.00 for this service. Thereafter

on March 14, 1975 T████ K████ H████ again returned to respondent's clinic believing that her left breast would be raised to the same level as her right breast. The procedure actually performed by respondent, however, was the removal of both implants and the insertion of different shaped implants into the patient's breasts. The last set of implants enlarged T████ H████'s breasts so that she was unable to extend her arms forward without her arms touching the outside of her breasts. She observed that her nipples pointed outward and their location was not appealing. A further result of the surgeries was a loss of considerable feeling in both breasts. At the present time T████ K████ H████ has very little feeling in either breast and she has since had further surgery to remove the implants in her breasts.

XVIII

On or about March 5, 1976 respondent performed an augmentation mammoplasty on patient C████ L████. Thereafter respondent administered postoperative care, the stitches were removed and Ms. L████ was told to return for continuing postoperative observation. Early in April 1976 Ms. L████ developed infections in both breasts. Thereafter, respondent saw the patient more often, he cleaned the breasts with water and peroxide and prescribed some powder which the patient was to apply to her breasts.

XIX

On June 8 or 9, 1976 respondent performed a second operation on C████ L████ to release the capsules in both breasts. The patient was informed by respondent that he drained blood and pus from the incisions during the surgery. Respondent did place a drain in the patient's left breast and this drain was left in for approximately one week. Postoperative care was continued and on July 9 it was determined that the right breast was hardening and possibly infected. On or about July 16, 1976 C████ L████ was advised by respondent that she would require a third surgery in order to correct the hardening in her right breast. Respondent performed a third surgery on Ms. L████ on July 27, 1976 to release the capsule in her right breast. Postoperative care continued and by August 20 the incision appeared to be healing. As time went on, however, an infection again developed in the right breast of C████ L████. By September 18 Ms. L████ right breast was painful and became discolored in the area of the incision. On September 20, 1976 the silicone implant in the right breast of C████ L████ broke and some of the silicone material spilled out. C████ L████ went to respondent's office but respondent was not there. One of respondent's employees did contact respondent by telephone and respondent was advised that the incision had opened and the implant was being held in the breast by a small amount of skin. Respondent suggested that his employee cut the skin and remove the implant, however, the employee was reluctant to take this action. Later that evening respondent returned to his office where respondent snipped the skin holding the implant in her right breast, he pressed from the top of the right breast and forced the implant out of the breast. Respondent did perform this procedure while he was in his street

clothes and in a non-sterile setting. He did, however, wash his hands prior to removing the implant and he did treat the infected area with some medication.

XX

The patient C██████ L██████ did from time to time receive medication to treat infections which developed. On September 22, 1976 respondent advised Ms. L██████ that she had an infection in her right breast and he prescribed Chloromycetin. Subsequently on September 30 or October 1 respondent prescribed Erythromycin. Subsequently on October 6, 1976 C██████ L██████ advised one of respondent's employees that the infection still had not cleared up and was still draining. Respondent at that point authorized a telephone prescription for Ampicillin. During the period from October 6 through November 2, 1976 C██████ L██████ did on various occasions contact one of respondent's employees by telephone. As a result of these contacts C██████ L██████ did receive Ampicillin, Chloromycetin and Vibramycin. It was not established, however, that this employee was prescribing any medication without respondent's prior direction. Respondent failed to take a blood smear of the patient C██████ L██████ until sometime after he first prescribed Chloromycetin for the patient. The patient C██████ L██████ became increasingly concerned about the failure of her infection to clear up. She last saw respondent on or about November 3, 1976. She declined to submit to any further surgical procedures and a day or so later she sought advice from another physician. C██████ L██████ was diagnosed as having a serious infection. She was hospitalized a short time later, a blood smear was taken and the infection was cleared up.

XXI

On or about July 17, 1976 a patient A██████ K██████ contracted with respondent for the performance of an abdominal lipectomy and a tubal ligation. On August 3, 1976 these procedures were performed upon that patient by respondent at his medical clinic on Wilshire Boulevard, known as Wilshire Surgical Clinic. Following the surgery an employee of respondent drove A██████ K██████ to her home. A██████ K██████ was scheduled to return to respondent's office on August 6, 1976 for postoperative care. She was informed that a car maintained by respondent would be sent to her residence to take her to the office. On August 5 the driver did not come to the residence of A██████ K██████. On the following day, August 6 the mother of A██████ K██████ took Ms. K██████ to respondent's medical clinic. Ms. K██████ was examined by an individual who she describes as a youthful Latin with curly hair. This individual introduced himself to Ms. K██████ as a doctor and stated that he assisted respondent in the operation of Ms. K██████. The Latin removed the bandages and commented that Ms. K██████'s stomach looked beautiful. A foul odor and drainage was noted as coming from the incision. Ms. K██████ complained about a great deal of pain. The

Latin advised Ms. K[REDACTED] to continue with the medication which she had been given. He bandaged the incision and told Ms. K[REDACTED] that he had applied a pressure bandage and that it must be removed in three days. On August 7 and 8, 1976 A[REDACTED] K[REDACTED] suffered extreme pain at the site of the abdominal incision. She and her mother repeatedly attempted to contact respondent but respondent was unavailable. On August 9, 1976 the date Ms. K[REDACTED] was scheduled to see respondent she was advised in a telephone conversation that the driver who was supposed to bring her into the office on that day was unable to pick her up. This individual advised Ms. K[REDACTED] that she had spoken with respondent and Ms. K[REDACTED] was to pull down her bandages and everything would be all right. Thereafter, on August 10 and on August 11 Ms. K[REDACTED] made repeated phone calls to respondent's office stating that she must be seen but she was advised by respondent's employees that respondent was unavailable. She was reassured that things would be all right. On August 11, 1976 A[REDACTED] K[REDACTED] was admitted to the emergency department of Kaiser Hospital in Harbor City. At that time she had a severe wound infection and massive abdominal wall cellulitis. A[REDACTED] K[REDACTED] has been left with a somewhat irregular scar. The scar is lower on one side than on the other. The shortcomings, however, are not extreme. Following the surgery she experienced numbness over the right lateral cutaneous nerve of the thigh. Evidently the lateral cutaneous femoral nerve was cut during surgery.

XXII

An organization known as Women's Advisory Council was originally located in Inglewood, California and thereafter relocated to offices at 1137 Second Street, Santa Monica, California. Vicki Amar, the wife of respondent, was one of the principals of this organization. Commencing at approximately June 1976 one Maurice Barbakow also known as Maury Barr became a principal in Women's Advisory Council. Actually Mr. Barbakow became the directing force behind the organization. A primary purpose of this organization was to advertise cosmetic surgery in the radio and press, to sell surgical procedures to individuals interested, collect adequate funds from the individuals and then to arrange for surgeons to perform the requested procedures. Respondent did perform many surgeries for individuals who had initially come to Women's Advisory Council. Other physicians were also employed by this organization to perform surgical services.

It became a rather common practice to prescribe certain drugs for patients to take commencing approximately five days prior to their scheduled surgery. Maurice Barbakow and Vicki Amar arranged with Lifetime Pharmacy to have these patients provided with the required medications. The pharmacist in each case would call the offices of respondent, the pharmacist would receive verification, a telephone prescription would be prepared and the medication would be issued to the patients as follows:

On or about November 30, 1976 at the business premises of the Women's Advisory Council located at 1137 Second Street, Santa Monica, California Maurice Barbakow furnished to E. S. [redacted] through Lifetime Pharmacy certain dangerous drugs namely Ampicillin, Ananase, and Synkayvite and again on December 10, 1976 Mr. Barbakow arranged for E. S. [redacted] to again obtain these same drugs through Lifetime Pharmacy. Lifetime Pharmacy verified the prescription with respondent's office and in each case respondent's name appeared on the containers as the prescribing physician.

B. On or about January 10, 1977 at the premises of Women's Advisory Council an individual who could not be identified at this hearing did arrange for L. B. [redacted] to obtain certain dangerous drugs namely Ampicillin, Ananase and Synkayvite through Lifetime Pharmacy. Respondent's office verified the prescription and respondent's name appeared as the prescribing physician.

C. On or about December 18, 1976 at the premises of Women's Advisory Council Maurice Barbakow arranged to have P. [redacted] M. [redacted] obtain certain dangerous drugs namely Ampicillin Ananase, and Synkayvite through Lifetime Pharmacy. The pharmacy verified the prescription with respondent's office and respondent's name appeared as the prescribing physician.

D. On or about January 11, 1977 at the premises of Women's Advisory Council an employee of the council arranged for B. T. [redacted] to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. The prescription was verified with respondent's office and respondent did appear as the prescribing physician.

E. On or about January 11, 1977 at the premises of Women's Advisory Council Maurice Barbakow arranged for M. H. [redacted] to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. The prescription was verified with respondent's office and respondent's name appeared as prescribing physician.

F. On or about November 5, 1976 at the premises of Women's Advisory Council Maurice Barbakow arranged for J. P. [redacted] to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. The prescription was verified with respondent's office and respondent's name appeared as the prescribing physician.

G. On or about November 26, 1976 at the premises of Women's Advisory Council Maurice Barbakow arranged for J. D. [redacted] C. [redacted] to obtain certain dangerous drugs through Lifetime Pharmacy namely Ampicillin, Ananase and Synkayvite. The prescription was verified with respondent's office and respondent's name appeared as prescribing physician.

Respondent did not conduct any physical examination with respect to any of the above listed patients prior to the time that they received the Ampicillin, Ananase or Synkayvite.

Maurice Barbakow, also known as Maury Barr, did not hold any license issued by any healing arts board which would authorize him to furnish or prescribe dangerous drugs. No employee of Women's Advisory Council who arranged for individuals to obtain dangerous drugs was ever the holder of any license issued by any healing arts board which would authorize such individual to prescribe dangerous drugs. However, it was not established that respondent ever authorized Maurice Barbakow or any employee of Women's Advisory Council to prescribe drugs for individuals. A spokesman for Women's Advisory Council would send the individual to the pharmacy and the pharmacy would verify the prescription with respondent's office and a telephone prescription would be prepared.

XXIII

During 1976 and continuing thereafter until the time of the hearing in January 1978 respondent maintained a clinic and medical offices at 6399 Wilshire Boulevard, Los Angeles, California. The building directory at that location identified respondent's business office and clinic as "Wilshire Cosmetic Surgical Clinic". The door to respondent's medical offices identify his practice as "Wilshire Surgical Clinic, Cosmetic and Gynecology".

During 1976 and 1977 respondent did maintain business cards at his place of business 6399 Wilshire Boulevard, Los Angeles, California. Respondent during this period of time did present business cards to various patients. The business cards bore the legend "Wilshire Surgical Clinic". At least one individual received a business card of respondent at the premises of Women's Advisory Council and from an employee of that organization. Respondent's business card bore the legend "Wilshire Surgical Clinic".

On or about April 7, 1976 respondent caused the June 1976 issue of the Pacific Telephone White Pages Directory for the Los Angeles Exchange, Central Section of the Los Angeles extended area to contain the following listing "Wilshire Cosmetic Group, 6399 Wilshire Bl 655-6945." In the same directory respondent also caused the following listing to appear. "Wilshire Surgical Clinic 6399 Wilshire Bl 655-6945".

In the August 1976 issue of the Pacific Telephone Yellow Page Directory for the Los Angeles Exchange, Central Section of the Los Angeles extended area respondent caused the following entry to appear.

"Amar Leroy J

Member American Medical Association
Wilshire Surgical Clinic
Cosmetic & Gynecological Surgery

Day or Night Call
6399 Wilshire Bl 655-6945"

In the same issue of the same directory respondent caused the following listing to appear.

"WILSHIRE SURGICAL CLINIC
Leroy's Amar M.D.
Member American Medical Association
Cosmetic & Gynecological Surgery
Day or Night Call
6399 Wilshire Bl. 655-6945"

At no time during the period commencing 1976 through 1977 did respondent have a valid permit issued by the Division of Licensing whereby respondent was registered or authorized to use the fictitious names of "Wilshire Cosmetic Surgical Clinic", "Wilshire Surgical Clinic", "Cosmetic and Gynecology", "Wilshire Surgical Clinic," or "Wilshire Cosmetic Group" and each of the above-described fictitious names was used in connection with the medical practice of respondent during the period commencing 1976 through 1977.

XXIV

The business enterprise known as Women's Advisory Council was directed and managed in part by respondent's wife, Vicki Amar and also Maurice Barbakow. Maurice Barbakow was the more dominant individual in this business enterprise. The Women's Advisory Council caused advertisements to be placed and published in the Los Angeles Times, a newspaper of general circulation. The advertisements offered to women a "No fee" consultation concerning "Facelifts" and other forms of plastic and cosmetic surgery. The ads further stated that financing for the cost of surgical procedures would be available and the ads as well as the name of the organization itself conveyed the impression that Women's Advisory Council was an organization with particular concern and sensitivity for women as a class. Individuals including E. S., L. B., P. M., B. T., M. H., J. P. and J. D. C., each responded to advertisements placed by Women's Advisory Council and each paid various sums or gave items of value either to Women's Advisory Council or to Maurice Barbakow or to Vicki Amar who was also known as Vicki Barbakow and these sums or items of value were paid to Women's Advisory Council or its principals as a deposit toward or in full payment for certain promised cosmetic surgical procedures. With respect to M. H. and J. P., respondent did perform the requested surgical procedures. With respect to E. S., L. B., P. M., B. T. and J. D. C., respondent did not perform any surgical procedures.

While indeed there was a continuing business relationship between Women's Advisory Council and respondent it was not established that Women's Advisory Council was an organization controlled by respondent, nor was it established that Vicki Amar, also known as Vicki

Barbakow or Maurice Barbakow, also known as Maury Barr, were ever agents or employees of respondent with respect to the operation of Women's Advisory Council. While it is true that respondent did perform surgical procedures on several individuals who came to Women's Advisory Council, it is also quite true that this organization referred patients to several other surgeons active in the cosmetic field. Actually, a great deal of hostility often existed between respondent and Maurice Barbakow as well as between respondent and Vicki Amar. Respondent did not pay for the advertising of Women's Advisory Council and he exercised no control over that organization.

XXV

Respondent was born in Louisiana where he received his early education. He attended Southern University but he received no degree from that institution. He served in the United States Army and part of this service was in the intelligence section. Following his discharge he returned to college and he received his Bachelor's degree in June 1959 from Tennessee State. Respondent commenced his medical education at Maherry Medical School in 1956. He did experience some academic difficulties. He left that institution and obtained his Bachelor's degree at Tennessee. He then returned to Maherry Medical College from 1959 through 1961 for personal reasons involving his marriage and pending divorce and attended Howard Medical School commencing in September 1961 until June 1963. Respondent received his medical degree from Howard University. Respondent interned at Freedman's Hospital during 1963 and 1964. He next went to Harlem Hospital in New York where he obtained a residency in obstetrics and gynecology. This was a surgical residency and a portion of his training was in general surgery. It was also during this period when respondent did assist in some breast surgeries. Respondent was admitted to practice medicine in the States of New York and Maryland.

Respondent came to California in 1966 and he was licensed to practice medicine in this state in May of that year. He was first employed by California Lutheran Hospital where he became chief of obstetrics and gynecology. In June 1967 respondent took the examination for Board certification in obstetrics and gynecology. Unfortunately, respondent failed this examination. Respondent has served in various hospitals in the Los Angeles area where he has worked largely in obstetrics and gynecology and he has also seen considerable service for various hospitals in the emergency room. Respondent became the director of the Hope Emergency Clinic in 1971 and also the Wall Street Medical Clinic. Later respondent became associated with Manchester Hospital and with University Hospital. It was during this period that respondent first met Mr. Dubin who at that time operated an ambulance service.

In 1974 respondent again met Mr. Dubin. By this time Mr. Dubin and his wife had founded an organization known as "Women Who Help Women." This organization did advertise and the advertisements were directed to women who would desire to obtain abortions. Respondent agreed to work for Women Who Help Women approximately one

day a week, and he initially performed abortions on patients which were obtained by the organization known as Women Who Help Women. Sometime in June or July 1974 the organization entered the field of cosmetic surgery and a Dr. John Brown was engaged to perform these procedures. Respondent wished to receive instruction in the field of plastic surgery and ultimately the officers of Women Who Help Women persuaded Dr. Brown to instruct respondent in this field. Dr. Brown was quite unhappy with the arrangement because he was also required to pay respondent \$1,000.00 a week which sum could otherwise be retained by Dr. Brown. Dr. Brown did not feel that respondent should be paid this fee while he was being instructed. Thereafter, for the most part respondent relied upon Dr. Brown for his instruction. He also assumed that Dr. Brown would require any pre-operative tests he deemed necessary and conduct any pre-operative physical examination. As time went on respondent undertook a few breast augmentation cases under the immediate direction of Dr. Brown. Respondent continued his instruction into other areas of plastic surgery and in the meantime he was attending various seminars conducted in the field of plastic surgery.

XXVI

Respondent opened his surgical clinic, Wilshire Surgical Center, late in 1974. In 1975 respondent was one of a group who purchased Manchester Community Hospital and renamed it Robert F. Kennedy Community Hospital. Respondent worked in the emergency room of Kennedy Hospital. There were other individuals who gave some services to the hospital evidently on a volunteer basis and at this time respondent met Mr. Maurice Barbakow who worked at the facility in some administrative capacity and he also worked on behalf of the Wilshire Surgical Clinic. The Robert F. Kennedy Community Hospital closed in December 1975. The financial problem of this facility was in part due to the fact that for some reason the hospital was not eligible to receive Medi-Cal payment from the State of California.

XXVII

Sometime in 1975 Henry Dubin formed the National Health and Appearance Foundation and Vicki Amar, respondent's wife, also founded the Women's Advisory Council. The funds needed to start Women's Advisory Council evidently came from the mother of Mrs. Amar. Maurice Barbakow became quite active in both the National Health and Appearance Foundation and also the Women's Advisory Council. It is quite true that these organizations did refer some patients to respondent for cosmetic surgery, however, at this time respondent did not control these organizations. Maurice Barbakow had previously suffered some form of criminal conviction for dishonest conduct. In approximately March 1976 he was rearrested. By this time respondent's wife had become emotionally involved with Maurice Barbakow. She persuaded respondent to engage counsel and to obtain Mr. Barbakow's release pending trial. At about this point in time Vicki Amar moved in with Maurice Barbakow and she began using the name Vicki Barbakow. Respondent became involved with a young lady who had for sometime been both an employee and social companion. Respondent and this young woman

resided at the Wilshire Surgical Clinic. In approximately July 1976 the National Health and Appearance Foundation was in serious financial trouble. Respondent took this organization over but business records were virtually non-existent. Respondent closed the office of the National Health and Appearance Foundation and had the telephone transferred to the Wilshire Surgical Clinic. Respondent's girl friend was assigned to this telephone and when calls were received she attempted to determine what surgery was promised, what amount was due and she would then consult with respondent to determine whether or not respondent might undertake this surgery.

XXVIII

Women's Advisory Council also experienced serious problems. Maurice Barbakow left the state apparently to face federal criminal charges. Vicki Amar suffered emotional problems and was hospitalized on various occasions. Again the business records of Women's Advisory Council were inadequate and outraged patients were threatening both civil and criminal action against Vicki Amar. After a great deal of consultation respondent agreed to perform numerous surgical procedures for persons who had paid sums to Women's Advisory Council. Women's Advisory Council ceased doing business early in 1977.

XXIX

Respondent has regularly attended seminars and continuing education programs in the field of cosmetic surgery for the past several years. He has attended programs presented by various California medical schools and various other educational programs conducted throughout the United States. He also attended a two week course in Brazil. Respondent does recognize that he is not qualified in all phases of cosmetic surgery and he feels that in part because of his race he did not have an opportunity to obtain a residency in plastic surgery.

XXX

As to the patient B█████ B█████ respondent does point out that this was Dr. Brown's patient. Respondent was not consulted with respect to the number of procedures which were performed. Respondent was at all times under the direction of Dr. Brown. The patient M█████ S█████ was also the patient of Dr. Brown. Respondent was an employee of the organization known as Women Who Help Women but at that time he was not employed as a surgeon or treating physician in the area of cosmetic surgery. The efforts M█████ S█████ to contact respondent evidently were unknown to respondent. Regarding L█████ S█████ respondent simply assumed that Dr. Brown had examined this patient prior to surgery and he notes that she received her doctor's permission to undergo this surgery. Respondent strongly denies that he would ever subject a patient to severe pain. Obviously any surgical procedure will cause concern to the patient but respondent does refer to his medical records which would indicate that the patient was appropriately sedated. Respondent does realize that one of Ms. S█████ ears was not placed in the proper position. He does not

feel that this establishes incompetence however, and he did offer to redo that ear without further cost to the patient. However, the patient declined any further procedures. Concerning the patient H████ B████ it is respondent's position that he did not leave drains in the breasts for seven or ten days. However, he does not know the precise time that drains were left in the breast. When the infections developed respondent did feel that it would be necessary to remove the implants in order to treat the infection. In his judgment, however, he felt that H████ B████ was quite emotional and she would become seriously upset if respondent attempted to remove the implants. As to respondent discharging the patient. It is his position that the patient's temperature had gone down to normal and respondent contends that it was the patient's mother who wished to take the patient out of the hospital. Even assuming that the mother wished to take H████ B████ from the hospital respondent was still under a duty to examine the patient and to decide if it was medically appropriate to discharge the patient. Concerning the patient T████ K████ H████ it is respondent's position that this patient never complained concerning the size of her breasts. He does concede that there were several surgeries. However, they were not all performed in order to obtain equal size and proper placement of the breasts. Respondent also contends that the surgeries did not leave multiple scars on this patient and all entries were made essentially through the same incision. Again respondent strongly denies that he would ever proceed with a surgery if the patient is suffering. As to the patient C████ L████ it is respondent's position his medical records show that this patient did not have a draining infection for a period of three months and actually many of the visits did indicate that the infection was clearing up. Respondent denies that he would perform surgical procedures through infected wounds. Concerning the prescriptions of Chloromycetin it is respondent's position that he gave a minimum prescription of this drug to the patient, which would not subject her to any appreciable risk. He feels that this drug is more commonly prescribed in other sections of the country and the world. Respondent did not permit his assistants to prescribe drugs and blood tests of this patient were in fact taken, however, none prior to the time that Chloromycetin was prescribed. Concerning the patient A████ K████ it is respondent's position that the surgery was in fact a good one and the scar while perhaps not perfect is not as bad as it is described in this accusation. Respondent never told this patient that stretch marks above the navel would be removed and he is at a loss to understand how the patient received this impression. Finally, respondent contends that he did not abandon this patient. He points out that he did see the patient three or four days after the surgery when the patient was brought in to his office by the patient's mother. He was personally unaware that his driver had some difficulty in picking up Ms. K████ for her office appointment. With respect to the balance of the charges respondent contends that many of his problems were caused by Mr. Maurice Barbakow an individual who took advantage of respondent in every particular. Mr. Barbakow apparently stole money from respondent and from other organizations such as the Women's Advisory Council. He would make extensive promises to clients in order to obtain funds and then he failed to pay these funds over to respondent or other surgeons for work which they performed. It is respondent's position that he did not control any of the organizations

including Women Who Help Women, the National Health and Appearance Foundation or the Women's Advisory Council. Actually these organizations retained several physicians from time to time to perform cosmetic surgery. Respondent was simply one of the physicians that would be retained. Actually respondent feels that he was of considerable assistance to many women who had paid money to these organizations but would not have received any surgery unless respondent had agreed to perform these surgeries for little or no compensation. Finally, it is respondent's position that he did consult with other cosmetic surgeons and he did confer with these individuals in many instances.

XXXI

The Board has before it a most controversial individual. He has been capable of extreme dedication in obtaining his medical education. He has presented letters from many friends and colleagues and these letters indicate that respondent is quite hardworking, conscientious and capable at least in the field of obstetrics and gynecology and when serving as a physician in a hospital emergency room. Respondent, however, has managed to tangle his professional and private life until they are intermingled to an astonishing degree. Respondent's ambition has certainly contributed to his untiring efforts to enter the field of cosmetic surgery in a manner and under a training program that is subject to serious question. Respondent has also demonstrated appalling shortcomings by allowing other individuals to manage his clinic, hospital and surgical practice. In many respects respondent was victimized but his carelessness made him a most attractive victim. In spite of his many errors this respondent is not an insensitive individual. He has been subjected to serious criticism from other physicians, he is presently a defendant in other law suits and as of the time of this hearing he is facing misdemeanor criminal charges. It is quite obvious that this respondent places the highest value upon his license to practice medicine. He has been deeply stunned by the numerous accusations that he has had to face and he is correct in pointing out that at least in some cases his former patients have become extremely hostile toward him and they have to some extent exaggerated his shortcomings. This respondent does not claim to be a perfect physician. He concedes that he has made some mistakes and he expresses a willingness to comply with any requirements of the Board. He does maintain, however, that he is fully capable of practicing good medicine and his misconduct is not nearly as extensive as his detractors contend.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

Under the provisions of Sections 2360 and 2361 of the Business and Professions Code the Division of Medical Quality has the authority to impose appropriate discipline where any licensee has committed acts or has been guilty of omissions which constitute grounds for disciplinary action.

A. Patient Ms. B■■■■:

Respondent did not perform any of the surgical procedures on Ms. B■■■■. Respondent was guilty of some degree of negligence where he raised no objection or at least made no inquiry concerning the simultaneous performance of four plastic surgical procedures. However, it was not established that such conduct amounted to gross negligence or gross incompetence.

B. Patient M■■■■ S■■■■:

Again respondent did not perform the surgery on this patient. As assisting surgeon, however, he was negligent to some degree concerning pre-operative records, but his conduct in this instance did not amount to gross negligence or gross incompetence.

C. Patient L■■■■ S■■■■:

Respondent was guilty of gross negligence and gross incompetence in proceeding with two life threatening operations on this patient without conducting a careful prior medical examination. The fact that this patient had a sunken chest causing the breasts to gravitate to the center of her chest does not amount to either gross incompetence or gross negligence. The fact that the autoplasty performed by respondent on the patient's left ear failed to substantially alter the position of that ear may demonstrate some degree of incompetence or negligence but not gross incompetence or gross negligence.

D. Patient H■■■■ B■■■■:

The fact that respondent left drains in the breast of this patient for several days did expose her to risk of infection. While this did demonstrate a degree of negligence and incompetence it did not establish gross negligence or gross incompetence. Respondent was also either negligent or incompetent in leaving the breast implants in place after the serious infection developed. Respondent's actions in this regard, however, again do not amount to either gross incompetence or gross negligence. Respondent was guilty of gross negligence and gross incompetence when he discharged H■■■■ B■■■■ from the hospital by telephone order at a time when she had an open wound in her right breast and an exposed implant. Even assuming that the mother of this patient desired her release from the hospital respondent had the compelling obligation to make a careful examination of this patient and to determine for himself whether it was appropriate to discharge her.

E. Patient T■■■■ K■■■■ H■■■■

It was not established that respondent was guilty of gross incompetence or gross negligence with respect to the insertion of implants. It was not established that these implants were successively larger. Respondent was guilty of gross incompetence

and gross negligence by virtue of the number of procedures that he was required to perform in order to obtain equal size and proper placement of the implants. It was not established that the patient was left with extensive scars by virtue of the multiple procedures. Respondent was guilty of gross negligence in performing the fourth surgery without appropriate anesthesia. Respondent may have believed that the patient was properly sedated but he certainly owed his patient the obligation of paying more attention to her complaints and insuring that she was comfortable during the procedure.

F. Patient C██████ L██████:

This patient did develop a serious infection. It would have been better to remove the implants and to cure the infection but this failure does not amount to gross negligence or that level of incompetence which would justify disciplinary action. Further, it was not established that at the time the subsequent procedures were performed the wounds were infected or exposed the patient to prolonged infection. Respondent was guilty of gross negligence and he was guilty of incompetence in failing to take preliminary blood studies prior to the prescription of Chloromycetin. Respondent was also guilty of gross negligence and incompetence in instructing his unlicensed assistant to remove the patient's ruptured implant. Respondent was not guilty of gross negligence or incompetence by virtue of his removal of this implant from his patient. Respondent did in fact wash his hands before removing the implant and the wound was treated immediately following the removal of the implant. It was not established that respondent permitted his assistant to prescribe antibiotics for this patient. Respondent was consulted and he did issue all of the prescriptions for this patient. Respondent did authorized and instruct his office assistant to remove the ruptured implant from the breast of C██████ L██████. This removal would have required the office assistant to cut a small amount of skin or flesh which was still holding the implant in the breast. In this regard respondent did aid and abet the unlicensed practice of medicine.

G. Patient A██████ K██████

Respondent was guilty of some degree of negligence and incompetence with respect to the location of the scar on this patient. This action, however, did not amount to gross negligence or that degree of incompetence which is required for disciplinary action. It does appear that respondent did cut the lateral cutaneous femoral nerve. It was not established that this amounted to gross negligence or that degree of incompetence which justifies disciplinary action. Respondent is not subject to disciplinary action for his failure to remove certain stretch marks. The stretch marks complained of by this patient could not be removed by the procedure performed by respondent. The problem here is not a case of negligence or incompetence but simply a misunderstanding between the patient and the physician. Respondent

has been guilty of gross negligence and incompetence in that A. [REDACTED] K. [REDACTED] was unable to contact respondent and to obtain promised treatment from respondent at a time when she was in serious need of respondent's care. Respondent promised this patient that he would provide transportation to his office for postoperative care. The patient relied on that promise and respondent was obligated to meet his commitment. The fact that respondent may not have been fully aware of this patient's problems is not persuasive. Respondent did know that he had operated on this patient and he was fully aware that she would require postoperative care. He had an obligation to be available should she have problems and respondent's conduct in this instance did amount to an abandonment of his patient.

Respondent has been guilty of gross negligence, of incompetence and of gross incompetence as set forth above and by such action he has subjected his license to disciplinary action pursuant to the provisions of Sections 2361(b) and (d) of the Business and Professions Code.

Respondent did prescribe dangerous drugs as defined in Section 4211 of the Business and Professions Code without a good faith prior examination or medical indication therefor as to the patients E. [REDACTED] S. [REDACTED], L. [REDACTED] B. [REDACTED], P. [REDACTED] M. [REDACTED], B. [REDACTED] T. [REDACTED], M. [REDACTED] H. [REDACTED], J. [REDACTED] P. [REDACTED] and J. [REDACTED] D. [REDACTED] C. [REDACTED]. By such conduct respondent violated Section 2399.5 of the Business and Professions Code and subjected his license to disciplinary action.

Respondent did suggest that an office assistant engage in a procedure which would have amounted to the unlawful practice of medicine and it would have amounted to a violation of Section 2141 of the Business and Professions Code. This office assistant, however, did not engage in the action which respondent requested. In view of the fact that the unlawful practice of medicine did not occur respondent did not aid or abet his office assistant in violating Section 2141 of the Business and Professions Code.

As to the prescriptions obtained by clients of Women's Advisory Council it was not established that respondent assisted in or abetted in the unlicensed practice of medicine by Maurice Barbakow or any other employee of Women's Advisory Council. The pharmacy verified all of the prescriptions with respondent's office and under these circumstances the prescriptions were issued by respondent and not by Maurice Barbakow or any other person. Respondent is not subject to disciplinary action for violation of Section 2392 of the Business and Professions Code.

Respondent did use a fictitious name and at the time of such use he did not hold a permit for such use issued by the Division of Licensing. By such conduct respondent did violate Section 2393 of the Business and Professions Code and he has subjected his license to disciplinary action.

This respondent was certainly closely associated with individuals who operated the Women's Advisory Council and similar

organizations. It was not established by a preponderance of the evidence, however, that respondent employed cappers or steerers or other persons in attempting to procure patients for his medical practice. Under these circumstances respondent is not subject to disciplinary action pursuant to the provisions of Section 2399 of the Business and Professions Code.

The facts established by respondent have been considered in making the order herein set forth. While it is true that some of respondent's problems may have been created or compounded by others this respondent has engaged in most serious misconduct. While respondent does possess many admirable qualities he has in many instances failed to exercise wisdom or prudence.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The Physician's and Surgeon's Certificate No. C28142 heretofore issued to respondent Leroy Amar, M.D. allowing him to practice as a physician and surgeon in the State of California is hereby revoked; provided, however, execution of said order of revocation is hereby stayed and respondent is placed on probation for a period of seven years from the effective date of this decision upon the following terms and conditions:

1. Respondent's certificate shall be suspended for a period of thirty (30) days and indefinitely thereafter until respondent shall take and successfully pass an oral and clinical examination as to his medical knowledge and skill in the field of obstetrics and gynecology and also in the emergency room practice.

Upon successfully passing said examination the suspension of respondent's certificate will be terminated and he shall be placed on probation for the remainder of the seven year period to the Division of Medical Quality upon the following terms and conditions:

A. Except as otherwise authorized by written consent of the Division of Medical Quality first obtained by respondent, respondent's practice under his certificate shall be solely limited to obstetrics and gynecology as well as emergency room work and all of respondent's practice shall be in a structured and supervised environment where respondent will be under the direct supervision of another licensee and the environment must first be approved by the Division before respondent may accept such employment and no change of employment shall occur without the prior authorization from the Division.

B. Within the first twenty-four months of probation the respondent must successfully complete a continuing education program approved in advance by the Division of Medical Quality or its designee.

C. Respondent shall report in person to the medical consultant of the Division of Medical Quality as directed in writing at the time and place so designated. Respondent shall be given at least fifteen days notice of the time and place of each required appearance.

E. Respondent shall provide quarterly reports to the Division of Medical Quality verifying that respondent has complied with all the conditions of his probation.


F. Respondent shall comply with the laws of the United States, the State of California and its political subdivisions and with the rules and regulations of the Board of Medical Quality Assurance.

G. Practice or residency outside the State of California shall toll the period of probation of this order unless written permission is first obtained from the Division of Medical Quality.

In the event respondent fails to comply with any of the above terms or conditions and during the period of his probation the Division of Medical Quality after providing notice to respondent and an opportunity to be heard may terminate respondent's probation effective immediately and reimpose the order of revocation or take such other action as the Division deems just and reasonable in its discretion. Upon full compliance with the terms and conditions of probation respondent's license shall be fully restored.

I hereby submit the foregoing which constitutes my Proposed Decision in the above entitled matter, as a result of the hearing had before me on the above dates, at Los Angeles, California, and recommend its adoption as the decision of the Division of Medical Quality, Board of Medical Quality Assurance.

DATED: 3-16-78


JOHN A. WILLD

Administrative Law Judge
Office of Administrative Hearings

JAW:mh

1 EVELLE J. YOUNGER, Attorney General
 2 DORA LEVIN, Deputy Attorney General
 3 800 Tishman Building
 3580 Wilshire Boulevard
 Los Angeles, California 90010
 Telephone: (213) 736-2004
 4 Attorneys for Complainant

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 8 BEFORE THE DIVISION OF MEDICAL QUALITY
 9 BOARD OF MEDICAL QUALITY ASSURANCE
 10 DEPARTMENT OF CONSUMER AFFAIRS
 11 STATE OF CALIFORNIA
 12

13 In the Matter of the Accusation
 14 Against:

15 LEROY AMAR, M.D.
 Physician's and Surgeon's
 Certificate No. C28142,

16 Respondent.
 17

NO. D-1977

ACCUSATION

18 Complainant alleges that:

19 1. Complainant, Joseph P. Cosentino, M.D., is the
 20 Acting Executive Director of the Board of Medical Quality
 21 Assurance (hereinafter referred to as the "Board"), and makes
 22 this Accusation solely in his official capacity.

23 2. On or about June 10, 1966, respondent Leroy
 24 Amar, M.D. (hereinafter referred to as "respondent"), was
 25 issued physician's and surgeon's certificate No. C28142 by the
 26 Board of Medical Examiners, predecessor agency to the Board.
 27 Said certificate is now, and was at all times mentioned herein,
 28 in full force and effect.

29 3. Pursuant to the provisions of sections 2360 and
 30 2361 of the Business and Professions Code, the Division of
 31 Medical Quality of the Board may discipline any licensee who

has committed any of the acts or omissions constituting grounds for disciplinary action.

4. At all times mentioned in paragraphs 5 to 10, unprofessional conduct has been defined, pursuant to Business and Professions Code section 2361(b) and (d), as gross negligence and gross incompetence, respectively.

5. Respondent is subject to discipline pursuant to the provisions of section 2361(b) and (d) of the Business and Professions Code in that respondent has committed acts of gross negligence and gross incompetence in his treatment of B██████ B██████, as more particularly alleged hereinafter:

A. On or about July 25, 1974, Ms. B██████ contracted with respondent's representative to have the respondent perform the following surgical procedures on her: face lift, breast lift (mastopexy), eyelid lift, and repair of a deviated septum (septoplasty). On or about August 27, 1974, respondent performed the following four operations on Ms. B██████: face lift, augmentation mammoplasty, eyelid lift, and a surgical procedure on said patient's nose.

B. On or about September 14, 1974, Ms. B██████ reported to the respondent that something in her right breast had slipped four days following surgery; and that she could not close her eyes.

1. Prior to January 1, 1975, section 2361, provided, inter alia, "... unprofessional conduct includes, but is not limited to the following . . . (c) gross incompetence." Effective January 1, 1975, said section was amended to read, inter alia, "Unprofessional conduct includes but is not limited to the following . . . (c) incompetence." Effective January 1, 1976, subdivision (c) of section 2361 was relettered subdivision (d).

At that time, respondent told the patient that her condition was progressing normally.

C. At the conclusion of respondent's treatment, on or about September 14, 1974, the patient was left in the following condition: she had a bad smell emanating from within her nose for several months following the surgery; the tip of her nose turned purple; her left breast became extremely hard; she could not close her eyes for approximately six months following surgery; and she has suffered a decrease in movement of her right eyebrow and of her forehead.

D. The treatment of Ms. B. constituted gross negligence and gross incompetence in the practice of medicine, as more particularly alleged hereinafter:

(1) The simultaneous performance of four plastic surgical procedures constitutes an undue risk to the patient. Additionally, the healing patterns of the four procedures performed by the respondent on Ms. B. are such that post-operative examination of the patient would not reveal the cause of certain post-operative complications.

(2) The patient engaged the respondent to perform a mastopexy, which was intended to elevate the patient's breasts. Instead, respondent performed an augmentation mammoplasty, which involves the surgical insertion of breast implants, thus giving the patient larger breasts, but failing to elevate them.

The procedure performed by respondent could not have elevated the patient's breasts.

(3) In performing the eyelid operation, respondent removed excessive tissue from the lower eyelid, leaving insufficient tissue in the eyelid to permit the patient to close her eyes.

(4) In performing the face lift operation, respondent made an incision too deep below the skin, damaging the temporal branch of the facial nerve, which caused the patient to lose movement of her right eyebrow and forehead.

(5) In performing the face lift operation, respondent pulled the patient's skin too tight, resulting in the loss of some facial expression.

(6) Despite the fact that some surgical procedure was performed on the patient's nose, respondent did not perform a septoplasty and failed to alter the deviation of the septum in any manner.

6. Respondent is further subject to discipline pursuant to the provisions of section 2361(b) and (d) of the Business and Professions Code in that respondent has committed acts of gross negligence and gross incompetence in his treatment of M. S., as more particularly alleged hereinafter:

A. In or about August 1974, M. S. contracted with a representative of the respondent to have a breast lift (mastopexy) performed by the respondent and Dr. John Brown. On or about

1 August 31, 1974, respondent and Dr. Brown performed
2 breast surgery on the patient.

3 B. On or about September 10, 1974, the
4 patient developed an abscess in her left breast
5 and unsuccessfully attempted to reach the respondent
6 or Dr. Brown for medical treatment. Both were
7 unavailable. The patient then sought treatment from
8 a general practitioner who treated her infection.

9 C. Following the surgery by respondent
10 and Dr. Brown, the patient had grossly deformed
11 breasts, which were asymmetrical in size and
12 extremely hard. Her left breast had a severe
13 indentation, where the patient had drained pus and
14 necrotic tissue.

15 D. Respondent's treatment of Ma [REDACTED] St [REDACTED]
16 constituted gross negligence and gross incompetence
17 in the practice of medicine, as more particularly
18 alleged hereinafter:

19 (1) The patient had contracted for
20 the performance of a mastopexy (breast lift)
21 by respondent and Dr. Brown, which involves
22 the removal of excess skin and the raising
23 of the nipples to a new position. Neither
24 of these procedures was performed on the
25 patient.

26 (2) The operating surgeons, the
27 respondent and Dr. Brown, did not prepare
28 any pre-operative pictures, pre-operative
29 records, or operative reports, which would
30 allow another physician to monitor the
31 patient's progress and determine whether

changes in her breasts were due to scarring,
or other causes.

(3) Respondent was unavailable for
post-operative treatment of the patient.
Said conduct constitutes abandonment of
the patient.

7. Respondent is further subject to discipline
pursuant to the provisions of section 2361(b) and (d) of the
Business and Professions Code in that respondent has committed
acts of gross negligence and gross incompetence in his treatment
of L. S., as more particularly alleged hereinafter:

A. On or about September 19, 1974, the
respondent performed an augmentation mammoplasty
and an otoplasty (ear modification) on L. S.
Prior to surgery, the patient informed respondent
that she had a heart problem. Respondent did not
examine the patient in any way prior to surgery,
and took no health history.

B. On or about September 21, 1974,
respondent examined the patient, and informed her
that she needed corrective surgery because her
right breast was smaller than her left. On or
about September 25, 1974, respondent again
performed breast surgery on the patient to
equalize the size of the breasts. Prior to the
surgery, Miss S. informed the respondent
that she did not wish to go through with the surgery.
Contrary to the patient's expressed desire,
respondent instructed the attending nurse to
administer medication to the patient, and
proceeded with the surgery. During the course of

1 the surgery, respondent removed the right breast
2 implant, and replaced it with one of identical
3 size. During the surgery, the patient informed
4 the respondent that she had chest pains, but
5 respondent did not stop the surgery, and did
6 not conduct any examination of her heart.

7 C. The respondent's treatment of
8 L. S. constituted gross negligence and
9 gross incompetence in the practice of medicine,
10 as more particularly alleged hereinafter:

11 (1) L. S. had a prolapsed
12 mitral heart valve, which made it extremely
13 dangerous for her to undergo any type of
14 surgery. Respondent, in this case,
15 performed two potentially life-threatening
16 operations on the patient, without conducting
17 any medical examination of her, despite the
18 fact that she had informed him that she had
19 a heart disease, and that she felt chest
20 pains during her second surgery.

21 (2) L. S. has a condition
22 called pectus excavatum (sunken chest).
23 The shape of her chest is such that breast
24 implants could not remain in a normal position,
25 but instead gravitate to the center of her
26 chest. The only possible way to perform an
27 augmentation mammoplasty on this patient
28 would have been to correct the pectus excavatum
29 first, so that the breast implants could be
30 properly located.

31 /

1 (3) The otoplasty performed by
2 respondent on the patient's left ear failed
3 to alter the position of the ear from its
4 pre-operative condition.

5 8. Respondent is further subject to discipline
6 pursuant to the provisions of section 2361(b) and (d) of the
7 Business and Professions Code in that respondent has committed
8 acts of gross negligence and gross incompetence in his treat-
9 ment of H [REDACTED] B [REDACTED], as more particularly alleged hereinafter:

10 A. On September 24, 1974, H [REDACTED] B [REDACTED]
11 had an augmentation mammoplasty performed by one
12 Dr. Berez.

13 B. On or about September 30, 1974,
14 the patient was examined by the respondent who
15 informed her that the September 24th surgery had
16 been improperly performed, and the respondent
17 redid the operation on that date, September 30th.
18 The respondent placed drains in both breasts,
19 leaving them in for ten days on the left side,
20 and seven days on the right side.

21 C. On or about October 10, 1974, both
22 of the patient's breasts were draining. The wound
23 on her right breast had opened and said opening
24 became progressively larger. The respondent
25 placed the patient on antibiotics, and had her
26 admitted to a hospital on October 12, 1974.

27 D. On or about October 14, 1974, the
28 respondent, without examining the patient,
29 discharged her from the hospital by telephone.
30 At the time of discharge, the wound on her right
31 breast was still open with the implant completely

1 exposed, and draining pus. The left breast was
2 hard, and showed evidence of a previous hematoma.

3 E. The treatment of H [REDACTED] B [REDACTED] constitutes
4 gross negligence and gross incompetence in the
5 practice of medicine, as more particularly alleged
6 hereinafter:

7 (1) Leaving of drains for ten days in
8 one instance, and seven days in the other,
9 exposed the patient to an unnecessary risk of
10 infection, which could travel up the drain
11 into the open wound.

12 (2) Leaving the breast implants in
13 place after extensive infection, made it
14 impossible to effectively treat the infection.
15 The only effective way to treat the infection
16 is to remove the implants.

17 (3) The patient should not have been
18 discharged from the hospital with an open
19 wound in her right breast and an exposed
20 implant. The discharging of the patient
21 from the hospital at a time when the wound
22 in her right breast was completely open,
23 exposing the implant, and draining pus, showed
24 a total disregard for the patient's health
25 and a complete abdication of medical
26 responsibility.

27 9. Respondent is further subject to discipline
28 pursuant to the provisions of section 2361(b) and (d) of the
29 Business and Professions Code in that respondent has committed
30 acts of gross negligence and gross incompetence in his treat-
31 ment of T [REDACTED] K [REDACTED] H [REDACTED] as more particularly alleged
32 hereinafter:

1 A. In or about September 1974, T [REDACTED]
2 K [REDACTED] H [REDACTED] contracted with respondent to have an
3 augmentation mammoplasty, which would slightly
4 enlarge her breasts. On or about September 11,
5 1974, respondent performed the surgery on
6 Miss H [REDACTED]. The implants placed by the respondent
7 were much larger than the patient had requested.
8 Following surgery, the patient developed large
9 areas of discoloration on her left arm and side.
10 Several weeks following the initial surgery, the
11 respondent performed a second operation on
12 Miss H [REDACTED], to remove the blood clot from her left
13 breast.

14 B. On or about November 4, 1974, respondent
15 performed a third operation on the patient, to
16 release the capsule which had formed in her left
17 breast, and to raise the right breast which was
18 not level with the left breast. Immediately
19 following the surgery, the left breast hardened,
20 and was much larger than the right.

21 C. On or about January 14, 1975, the
22 respondent performed a fourth surgery on the
23 patient, in order to enlarge the left breast to
24 make it equal in size to the right one. Respondent
25 failed to anesthetize the patient, so that she
26 was awake during surgery, and suffered unnecessary
27 pain during surgery.

28 D. On or about March 14, 1975, the
29 patient returned to the respondent in order to
30 have the left breast raised to the same level as
31 the right. The surgery actually performed by

1 the respondent involved removal of the implants
2 and insertion of larger and rounder implants into
3 the patient's breasts. The last set of implants
4 was so large, that she could not move her arms
5 straight forward, but had to move them around her
6 breasts. Following the last surgery, the patient
7 has had numbness in both breasts, and her nipples
8 point outward in a deformed manner.

9 E. Respondent's treatment of T [REDACTED] K [REDACTED]
10 H [REDACTED] constitutes gross negligence and gross
11 incompetence in the practice of medicine, as more
12 particularly alleged hereinafter:

13 (1) Respondent inserted implants
14 which were successively larger, eventually
15 giving the patient implants so large that
16 she was precluded from moving her arms in
17 a normal manner.

18 (2) Respondent should not have been
19 required to perform five surgeries to obtain
20 equal size and proper placement of the breasts.
21 The multiple number of procedures performed
22 by the respondent in order to obtain equal
23 size and placement of the breasts shows a
24 substantial lack of knowledge of the procedure.

25 (3) As a result of the multiple
26 procedures performed by the respondent, the
27 patient was left with extensive scars on her
28 breasts.

29 (4) Respondent should not have performed
30 the fourth surgery without anesthesia. The lack
31 of proper anesthesia during the patient's fourth

surgery shows a total disregard for the patient's health and welfare.

10. At all times mentioned in paragraph 11, Business and Professions Code section 2361(b) and (d)^{2/} defined unprofessional conduct as gross negligence and incompetence.

11. Respondent is further subject to discipline pursuant to the provisions of section 2361(b) and (d) of the Business and Professions Code in that respondent has committed acts of gross negligence and incompetence in his treatment of C [REDACTED] L [REDACTED], as more particularly alleged hereinafter:

A. On or about March 5, 1976, the respondent performed an augmentation mammoplasty on C [REDACTED] L [REDACTED]. Approximately one month following the surgery, the patient developed infections in both breasts, which infections continued for approximately three months. Respondent was aware of the progression of the infections.

B. On or about June 2, 1976, the respondent performed a second operation on C [REDACTED] L [REDACTED] to release the capsules in both breasts. The respondent told the patient that he drained blood and pus from the incisions during surgery. The respondent placed a drain

2. Prior to January 1, 1975, section 2361, provided, inter alia, ". . . unprofessional conduct includes, but is not limited to the following . . . (c) gross incompetence." Effective January 1, 1975, said section was amended to read, inter alia, "Unprofessional conduct includes but is not limited to the following . . . (c) incompetence." Effective January 1, 1976, subdivision(c) of section 2361 was relettered subdivision (d).

1 in the patient's left breast, leaving the drain
2 in for a week.

3 C. On or about July 27, 1976, the
4 respondent operated on C [REDACTED] L [REDACTED] a third time,
5 to correct the hardening in the right breast which
6 had developed.

7 D. On or about September 18, 1976, the
8 incision in the patient's right breast was open,
9 and an infection in her right breast was apparent.
10 On or about September 20, 1976, the silicone
11 implant in her right breast broke, and the silicone
12 spilled out onto her body. C [REDACTED] L [REDACTED] attempted
13 to contact the respondent, and was told by respondent's
14 assistant that he was unavailable, and that the
15 assistant would attempt to treat the patient.

16 E. On or about September 20, 1976, the
17 patient went to respondent's office, where the
18 assistant, at respondent's direction, attempted to
19 push the implant in the patient's right breast out
20 through the opening at the site of the incision.
21 That evening, respondent saw the patient in his
22 office, where he enlarged the opening in her right
23 breast, and pulled out the implant. Respondent
24 carried out this operation in a non-sterile setting;
25 he was wearing his street clothes, and did not wash
26 his hands or wear gloves.

27 F. On or about September 22, 1976,
28 respondent informed the patient that she had an
29 infection in her right breast, and prescribed
30 Chloromycetin for her.

31 /

1 G. On or about September 30, 1976, the
2 respondent saw the patient again, and prescribed
3 Erythromycin.

4 H. On or about October 6, 1976, the
5 patient attempted to reach respondent, to ask for
6 further advice, since her infection was still
7 draining. Respondent was unavailable, and
8 respondent's assistant prescribed Ampecillin for
9 the patient. During the period between October 6
10 and November 2, respondent's assistant prescribed
11 Ampicillin, then Chloromycetin, and finally
12 Vibramycin for the patient. During this time,
13 respondent remained unavailable for consultation
14 with the patient.

15 I. On or about November 2, 1976, respondent
16 finally examined the patient and confirmed that her
17 infection was still present. The respondent took
18 a smear from the patient's right breast at this
19 time.

20 J. The treatment of C. L. consti-
21 tuted gross negligence and incompetence in the
22 practice of medicine, as more particularly alleged
23 hereinafter:

24 (1) The respondent failed to remove
25 the patient's implants, despite a draining
26 infection which lasted for three months.
27 The only effective treatment of such an
28 infection is to remove the implants.

29 (2) The performance of surgical
30 procedures through infected wounds, and
31 the reclosure of such wounds, exposed the
32 patient to prolonged infection.

(3) The prescription of Chrolomycetin without preliminary blood studies, exposed the patient to substantial risk in that this drug has serious side effects, including aplastic anemia which may result in death, and there are numerous other drugs which could have been used in this situation.

(4) Respondent should not have instructed his assistant to remove the patient's ruptured implant but should have done so himself.

(5) The removal of the ruptured implant by the respondent in his street clothes, without either washing his hands or wearing gloves, exposed the patient to an undue risk of infection.

(6) Respondent should not have permitted his assistant to prescribe antibiotics, especially Chloromycetin which exposed the patient to undue risk of side effects, including death.

12. Respondent is further subject to discipline pursuant to the provisions of section 2361(a) of the Business and Professions Code, in conjunction with section 2141 of the Business and Professions Code, in that respondent has aided and abetted the unlicensed practice of medicine, as more particularly alleged hereinafter:

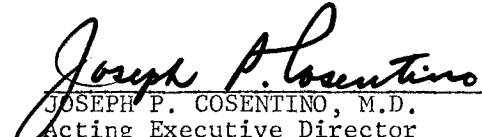
A. During the treatment of C. L. L. alleged above, respondent authorized his office assistant, who was not a licensed physician and surgeon, to treat the patient, by attempting to remove the ruptured implant from her breast, as well as authorizing her to prescribe antibiotics for the patient.

1 B. On or about June 3, 1974, respondent
2 authorized one Miriam Aulmann to give injections
3 to respondent's patients. Miriam Aulmann did not
4 then hold any license issued by any healing arts
5 board.

6 C. On or about July 23, 1974, respondent
7 authorized E. Domino Butler to administer injections
8 to respondent's patients. E. Domino Butler did not
9 then hold any license issued by any healing arts
10 board.

11 WHEREFORE, complainant requests that a hearing be
12 held on the matters alleged herein, and that following said
13 hearing, the Division of Medical Quality issue a decision
14 suspending or revoking respondent's license; and taking such
15 other action as the Division deems proper.

16 DATED: 3-25-77.

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19 
20 JOSEPH P. COSENTINO, M.D.
21 Acting Executive Director
22 Board of Medical Quality Assurance
23 State of California

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28
29
30
31 Complainant

EVELLE J. YOUNGER, Attorney General
of the State of California
DORA LEVIN, *Deputy*
M. GAYLE ASKREN, *Deputy*
Deputy Attorneys General
3580 Wilshire Boulevard, Suite 800
Los Angeles, California 90010
Telephone: (213) 736-2004

Attorneys for Complainant

BEFORE THE DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation
Against:

LEROY AMAR, M.D.
Physician's and Surgeon's
Certificate No. C-28142,

Respondent.

NO. D-1977

FIRST SUPPLEMENTAL
ACCUSATION

Complainant, Joseph P. Cosentino, M.D., alleges that he
is the Acting Executive Director of the Board of Medical Quality
Assurance (hereinafter referred to as "Board") and that he makes
this Supplemental Accusation solely in his official capacity;
complainant further alleges that:

13. Section 2399.5 of the Business and Professions
Code ^{3/} provides, inter alia, that prescribing, dispensing or fur-
nishing dangerous drugs as defined in section 4211 without a good
faith prior examination and medical indication therefor, consti-
tutes unprofessional conduct.

14. Respondent is subject to discipline pursuant to
the provisions of section 2361(a), in conjunction with section

3. Section references are to the Business and Professions
Code.

1 2399.5, in that respondent has assisted in or abetted the pre-
2 scribing, dispensing or furnishing of dangerous drugs without a
3 good faith prior examination and medical indication therefor, as
4 more particularly alleged hereinafter:

5 A. E [REDACTED] S [REDACTED]

6 (1) On or about November 30, 1976, at
7 the business premises of the Women's Advisory Council
8 (hereinafter "WAC") located at 1137 2nd Street,
9 Santa Monica, California, MAURICE BARBAKOW furnished
10 to E [REDACTED] S [REDACTED] certain dangerous drugs, as defined
11 in section 4211; namely, Ampicillin, Ananase, and
12 Synkayvite.

13 (2) On or about December 10, 1976, at the
14 aforesaid business premises of WAC, MAURICE BARBAKOW
15 prescribed for E [REDACTED] S [REDACTED] certain dangerous drugs
16 as defined in section 4211; namely, Ampicillin,
17 Ananase, and Synkayvite.

18 (3) The furnishing and prescribing, re-
19 spectively, of the dangerous drugs as set forth
20 hereinabove in paragraphs (1) and (2) were done
21 without a good faith prior examination and without
22 a medical indication for said dangerous drugs.

23 (4) On or about November 30, 1976, and
24 December 10, 1976, respondent authorized MAURICE
25 BARBAKOW to furnish and to prescribe, respectively,
26 the dangerous drugs as set forth hereinabove in
27 paragraphs (1) and (2); respondent's name appeared
28 upon the label of each container of drugs received
29 by E [REDACTED] S [REDACTED]

30 /

31 /

1 B. L [REDACTED] B [REDACTED] D

2 (1) On or about January 10, 1977, at the
3 aforesaid business premises of WAC, the receptionist
4 employee of WAC prescribed for L [REDACTED] B [REDACTED] certain
5 dangerous drugs as defined in section 4211; namely,
6 Ampicillin, Ananase, and Synkayvite.

7 (2) The prescribing of the dangerous drugs
8 as set forth hereinabove in paragraph (1) was done
9 without a good faith prior examination and without a
10 medical indication for said dangerous drugs.

11 (3) On or about January 10, 1977, respon-
12 dent authorized said receptionist to prescribe the
13 dangerous drugs as set forth hereinabove in paragraph
14 (1); respondent's name appeared upon the label of
15 each container of drugs received by L [REDACTED] B [REDACTED].

16 C. P [REDACTED] M [REDACTED]

17 (1) On or about December 18, 1976, at the
18 aforesaid business premises of WAC, MAURICE BARBAKOW
19 furnished to P [REDACTED] M [REDACTED], certain dangerous
20 drugs as defined in section 4211; namely, Ampicillin,
21 Ananase, and Synkayvite.

22 (2) The furnishing of the dangerous drugs
23 as set forth hereinabove in paragraph (1) was done
24 without a good faith prior examination and without a
25 medical indication for said dangerous drugs.

26 (3) On or about December 18, 1976, respon-
27 dent authorized MAURICE BARBAKOW to prescribe the
28 dangerous drugs as set forth hereinabove in paragraph
29 (1); respondent's name appeared upon the label of
30 each container of drugs received by P [REDACTED] M [REDACTED].

31 /

1 D. B [REDACTED] T [REDACTED]

2 (1) On or about January 11, 1977, at the
3 aforesaid business premises of WAC, MAURICE BARBAKOW
4 or an unknown individual acting under the orders of
5 MAURICE BARBAKOW furnished to B [REDACTED] T [REDACTED] certain
6 dangerous drugs as defined in section 4211; namely,
7 Ampicillin, Ananase, and Synkayvite.

8 (2) The furnishing of the dangerous drugs
9 as set forth hereinabove in paragraph (1) was done
10 without a good faith prior examination and without a
11 medical indication for said dangerous drugs.

12 (3) On or about January 11, 1977, respon-
13 dent authorized MAURICE BARBAKOW or the aforesaid
14 unknown individual acting under the orders of MAURICE
15 BARBAKOW or directly under authority of respondent,
16 to furnish the dangerous drugs as set forth herein-
17 above in paragraph (1); respondent's name appeared
18 upon the label of each container of drugs received
19 by B [REDACTED] T [REDACTED].

20 E. M [REDACTED] H [REDACTED]

21 (1) On or about January 11, 1977, at the
22 aforesaid business premises of WAC, MAURICE BARBAKOW
23 prescribed for M [REDACTED] H [REDACTED] certain dangerous drugs
24 as defined in section 4211; namely, Ampicillin,
25 Ananase, and Synkayvite.

26 (2) The prescribing of the dangerous drugs
27 as set forth hereinabove in paragraph (1) was done
28 without a good faith prior examination and without a
29 medical indication for said dangerous drugs.

30 (3) On or about January 11, 1977, respon-
31 dent authorized MAURICE BARBAKOW to prescribe the

1 dangerous drugs as set forth hereinabove in paragraph
2 (1); respondent's name appeared upon the label of each
3 container of drugs received by M [REDACTED] H [REDACTED].

4 F. J [REDACTED] P [REDACTED]

5 (1) On or about November 5, 1976, at the
6 aforesaid business premises of WAC, MAURICE BARBAKOW
7 also known as MAURY BARR, prescribed for J [REDACTED] P [REDACTED]
8 certain dangerous drugs as defined in section 4211;
9 namely, Ampicillin, Ananase, and Synkayvite.

10 (2) The prescribing of the dangerous drugs
11 as set forth hereinabove in paragraph (1) was done
12 without a good faith prior examination and without a
13 medical indication for said dangerous drugs.

14 (3) On or about November 5, 1976, respon-
15 dent authorized MAURICE BARBAKOW, also known as MAURY
16 BARR, to prescribe the dangerous drugs as set forth
17 hereinabove in paragraph (1); respondent's name
18 appeared upon the label of each container of drugs
19 received by J [REDACTED] P [REDACTED].

20 G. J [REDACTED] D [REDACTED] C [REDACTED]

21 (1) On or about November 26, 1976, at the
22 aforesaid business premises of WAC, MAURICE BARBAKOW
23 furnished to J [REDACTED] D [REDACTED] C [REDACTED] certain dangerous
24 drugs as defined in section 4211; namely, Ampicillin,
25 Ananase, and Synkayvite.

26 (2) The furnishing of the dangerous drugs
27 as set forth hereinabove in paragraph (1) was done
28 without a good faith prior examination and without a
29 medical indication for said dangerous drugs.

30 (3) On or about November 26, 1976, respon-
31 dent authorized MAURICE BARBAKOW to furnish the

1 dangerous drugs as set forth hereinabove in paragraph
2 (1); the respondent's name appeared upon the label of
3 each container of drugs received by J [REDACTED] D [REDACTED] C [REDACTED].

4 15. Respondent is further subject to discipline pursuant
5 to the provisions of section 2361(a), in conjunction with section
6 2392, in that respondent has assisted in or abetted the unlicensed
7 practice of medicine, as more particularly alleged hereinafter:

8 A. Complainant incorporates paragraph 14 herein
9 by reference as though fully set forth at this point.

10 B. Prescribing and furnishing the dangerous
11 drugs as set forth hereinabove in paragraph 14 constitutes
12 the unlicensed practice of medicine.

13 C. MAURICE BARBAKOW, also known as MAURY BARR,
14 did not at any time mentioned herein hold any license
15 issued by any healing arts board which would authorize
16 the furnishing or prescribing by him of dangerous drugs.

17 D. The receptionist employee of WAC, whose
18 actions have been alleged hereinabove in paragraph 14 B,
19 did not at any time mentioned herein hold any license
20 issued by any healing arts board which would authorize
21 the prescribing by her of dangerous drugs.

22 E. The unknown individual acting under the
23 orders of MAURICE BARBAKOW, as alleged hereinabove in
24 paragraph 14 D, did not at any time mentioned herein hold
25 any license issued by any healing arts board which would
26 authorize the furnishing by him of dangerous drugs.

27 16. Section 2393 provides, inter alia, that the use of
28 any fictitious name or name other than his own by the holder of
29 any certificate in any sign or advertisement constitutes unprofes-
30 sional conduct unless such certificate holder first has obtained
31 a valid permit issued by the Division of Licensing of the Board.

1 17. Respondent is subject to discipline pursuant to the
2 provisions of sections 2361 and 2393 in that respondent has used
3 a fictitious name without, at the time of such use, holding an
4 outstanding, unexpired, unsuspended, and unrevoked permit for such
5 use issued by the Division of Licensing, as more particularly
6 alleged hereinafter:

7 A. During 1976 and through and including March
8 of 1977, at business premises located at 6399 Wilshire
9 Boulevard, Los Angeles, California, respondent certificate
10 holder caused the building directory of tenants to identify
11 his practice as the "WILSHIRE COSMETIC SURGICAL CLINIC";
12 during the same time period, and at the aforementioned
13 address, respondent certificate holder caused the door to
14 his suite of medical offices to identify the practice as
15 the "WILSHIRE SURGICAL CLINIC, COSMETIC AND GYNECOLOGY."

16 B. During 1976, at respondent's business address
17 of 6399 Wilshire Boulevard, Los Angeles, California, E [REDACTED]
18 S [REDACTED] received the business card of respondent which had
19 printed on its face the words "WILSHIRE SURGICAL CLINIC."

20 C. On or about January 25, 1977, at the WAC
21 business address referred to hereinabove at paragraph 14,
22 L [REDACTED] B [REDACTED] received a business card of respondent
23 which had printed on its face the words "WILSHIRE SURGICAL
24 CLINIC" and the address "6399 Wilshire Boulevard, Suite
25 419, Los Angeles, California."

26 D. In or about February of 1977, L [REDACTED] B [REDACTED]
27 visited respondent's office at 6399 Wilshire Boulevard,
28 Los Angeles, California, met with respondent who agreed to
29 perform a face lift for her, and received the business card
30 of respondent which had printed on its face the words
31 "WILSHIRE SURGICAL CLINIC."

1 E. On or about April 7, 1976, respondent
2 caused the June 1976 issue of the Pacific Telephone White
3 Pages Directory for the Los Angeles Exchange, Central
4 Section of the Los Angeles Extended Area, to contain the
5 following listing, at page 1119: "Wilshire Cosmetic Group
6 6399 Wilshire Bl 655-6945." In the same issue of the
7 same directory, respondent caused the following listing
8 to appear, at page 1120: "WILSHIRE SURGICAL CLINIC
9 6399 Wilshire Bl.....655-6945."

10 F. On or about May 18, 1976, respondent caused
11 the August 1976 issue of the Pacific Telephone Yellow
12 Pages Directory for the Los Angeles Exchange, Central
13 Section of the Los Angeles Extended Area, to contain the
14 following listing, at page 1515:

15 "Amar Leroy J

16 Member American Medical Association

17 Wilshire Surgical Clinic

18 Cosmetic & Gynecological Surgery

19 Day or Night Call

20 6399 Wilshire Bl.....655-6945"

21 In the same issue of the same directory, respondent caused
22 the following listing to appear, at page 1544:

23 "WILSHIRE SURGICAL CLINIC

24 Leroy's Amar M.D.

25 Member American Medical Association

26 Cosmetic & Gynecological Surgery

27 Day or Night Call

28 6399 Wilshire Bl.....655-6945"

29 G. At no time during the period alleged herein-
30 above in paragraph 17 did respondent certificate holder
31 have a valid permit issued by the Division of Licensing

1 to use the fictitious names "WILSHIRE COSMETIC SURGICAL
2 CLINIC," "WILSHIRE SURGICAL CLINIC, COSMETIC AND
3 GYNECOLOGY," "WILSHIRE SURGICAL CLINIC," or "WILSHIRE
4 COSMETIC GROUP," although each of the aforesaid fictitious
5 names was used in connection with the medical practice of
6 respondent during that time period.

7 18. Respondent is subject to discipline pursuant to
8 the provisions of sections 2361 and 2399 in that respondent has
9 employed "cappers," "steerers," or other persons in procuring or
10 attempting to procure patients for his medical practice, as more
11 particularly alleged hereinafter:

12 A. Complainant incorporates paragraph 14 herein
13 by reference as though fully set forth at this point.

14 B. Acting through his representative, MAURICE
15 BARBAKOW, during 1976 and 1977, respondent caused adver-
16 tisements to be placed and published in the LOS ANGELES
17 TIMES, a newspaper of general circulation.

18 C. The advertisements referred to hereinabove
19 in paragraph 18 B,

20 (1) Offered to women a "no fee" consulta-
21 tion concerning "face lifts" and other forms of
22 plastic and cosmetic surgery;

23 (2) Stated that financing was unavailable;

24 (3) Implied an organization of women with
25 a special humanitarian concern and sensitivity for
26 women as a class, through the use of the name
27 "WOMEN'S ADVISORY COUNCIL."

28 D. In truth and fact, respondent and BARBAKOW
29 used the responses thus gained from such advertising to
30 generate the patients for the medical practice of respon-
31 dent.

1 E. On or about October 26, 1976, E[REDACTED] S[REDACTED],
2 referred to hereinabove at paragraph 14 A, answered the
3 advertisement placed pursuant to the scheme set forth
4 hereinabove at paragraphs 18 B, C, and D; and was told by
5 MAURICE BARBAKOW that respondent was to be one of the
6 surgeons who would perform the requested abdominal oper-
7 ation. Between October 26, 1976, and January 27, 1977,
8 E[REDACTED] S[REDACTED] paid MAURICE BARBAKOW cash and property
9 (crystal) worth a total of approximately \$810; a portion
10 of said total was her check in the amount of \$250 payable
11 to WOMEN'S ADVISORY COUNCIL.

12 F. On or about January 3, 1977, L[REDACTED] B[REDACTED],
13 referred to hereinabove at paragraph 14 B, answered the
14 advertisement placed pursuant to the scheme set forth
15 hereinabove at paragraphs 18 B, C, and D; on or about
16 January 5, 1977, L[REDACTED] B[REDACTED] gave her check in the
17 amount of \$1,000 to VIKKI BARBAKOW, also known as VERONICA
18 BARBAKOW, payable to the order of WOMEN'S ADVISORY COUNCIL
19 for the requested face lift operation. On or about
20 January 23, 1977, L[REDACTED] B[REDACTED] paid WAC an additional
21 \$100.

22 G. On or about November 17, 1976, P[REDACTED]
23 M[REDACTED], referred to hereinabove at paragraph 14 C,
24 answered the advertisement placed pursuant to the scheme
25 set forth hereinabove at paragraph 18 B, C, and D; on or
26 about December 18, 1976, P[REDACTED] M[REDACTED] paid \$1,000 to
27 MAURICE BARBAKOW for the requested breast implant operation,
28 which was then scheduled to be performed on January 28,
29 1977. On or about December 18, 1976, P[REDACTED] M[REDACTED],
30 while at WAC, received the dangerous drugs hereinabove
31 alleged at paragraph 14 C; imprinted upon the labels of

1 each of the containers of said drugs was the name of respon-
2 dent.

3 H. On or about January 11, 1977, B. [REDACTED] T. [REDACTED],
4 referred to hereinabove at paragraph 14 D, answered the
5 advertisement placed pursuant to the scheme set forth
6 hereinabove at paragraphs 18 B, C, and D. On said date,
7 B. [REDACTED] T. [REDACTED] gave a check in the amount of \$1,000 to
8 MAURICE BARBAKOW, payable to the order of WOMEN'S ADVISORY
9 COUNCIL. Also, on said date, B. [REDACTED] T. [REDACTED], while at
10 WAC, received the dangerous drugs hereinabove alleged at
11 paragraph 14 D; imprinted upon the labels of each of the
12 containers of said drugs was the name of respondent.

13 I. On or about September 23, 1976, M. [REDACTED] H. [REDACTED],
14 referred to hereinabove at paragraph 14 E, answered the
15 advertisement placed pursuant to the scheme set forth
16 hereinabove at paragraphs 18 B, C, and D. On or about
17 September 27, 1976, M. [REDACTED] H. [REDACTED] gave her check in the
18 amount of \$2,000 to MAURICE BARBAKOW, payable to the order
19 of WOMEN'S ADVISORY COUNCIL. On or about October 7, 1976,
20 M. [REDACTED] H. [REDACTED] gave her check in the amount of \$2,000 to
21 MAURICE BARBAKOW, payable to the order of WOMEN'S ADVISORY
22 COUNCIL, in full payment for the requested face lift and
23 eyelid operation. On or about October 7, 1976, at the
24 Bella Vista Community Hospital, 5425 East Pomona Boulevard,
25 Los Angeles, California, respondent performed the requested
26 operations upon M. [REDACTED] H. [REDACTED].

27 J. On or about September 2, 1976, J. [REDACTED] P. [REDACTED],
28 referred to hereinabove at paragraph 14 F, answered the
29 advertisement placed pursuant to the scheme set forth
30 hereinabove at paragraphs 18 B, C, and D. On or about
31 September 2, 1976, J. [REDACTED] P. [REDACTED] gave her check in the

1 amount of \$500 to MAURICE BARBAKOW, payable to the order
2 of WOMEN'S ADVISORY COUNCIL, as a down payment for a re-
3 quested abdominal cosmetic surgical procedure. On or
4 about November 30, 1976, J [REDACTED] P [REDACTED] purchased and gave
5 a cashier's check in the amount of \$1,350 to respondent's
6 WILSHIRE SURGICAL CLINIC as further payment for the afore-
7 mentioned operation. On or about December 3, 1976, at
8 the Doctors Hospital of Compton, 950 West Alondra Boulevard,
9 Compton, California, respondent performed the aforementioned
10 operation.

11 K. On or about November 25, 1976, J [REDACTED] D [REDACTED]
12 C [REDACTED], referred to hereinabove at paragraph 14 G, answered
13 the advertisement placed pursuant to the scheme set forth
14 hereinabove at paragraphs 18 B, C, and D. On or about
15 November 26, 1976, J [REDACTED] D [REDACTED] C [REDACTED] gave her check in
16 the amount of \$1,500 to MAURICE BARBAKOW, payable to the
17 order of WOMEN'S ADVISORY COUNCIL, as a deposit for a re-
18 quested lipectomy. Also on November 26, 1976, J [REDACTED]
19 D [REDACTED] C [REDACTED], while at WAC, received the dangerous drugs here-
20 inabove alleged at paragraph 14 G; imprinted upon the labels
21 of each of the containers of said drugs was the name of
22 respondent.

23 19. Respondent is further subject to discipline pur-
24 suant to the provisions of section 2361(b) and (d) of the Business
25 and Professions Code in that respondent has committed acts of
26 gross negligence and incompetence in his treatment of APHRODITE
27 KALLIOS, as more particularly alleged hereinafter:

28 A. On or about July 17, 1976, A [REDACTED] K [REDACTED]
29 contracted with respondent for the performance of an
30 abdominal lipectomy and a tubal ligation. On or about
31 August 3, 1976, the respondent performed both these pro-
32 cedures on A [REDACTED] K [REDACTED]

1 B. During the three days following the surgery,
2 A [REDACTED] K [REDACTED] experienced great pain, and was unable
3 to walk erect. She also suffered nightmares caused by
4 sleeping pills and Darvon prescribed by the respondent.

5 C. On or about August 6, 1976, A [REDACTED] K [REDACTED]
6 was examined by an associate of the respondent at respon-
7 dent's place of practice. Respondent's associate told
8 A [REDACTED] K [REDACTED] that there was seepage from the abdominal
9 incision, and that she could get an infection. The associate
10 reassured her that everything was all right, and told her
11 that it was imperative that she return in three days to
12 have her bandage changed.

13 D. On August 7 and 8, 1976, A [REDACTED] K [REDACTED]
14 suffered extreme pain at the site of the abdominal incision.
15 She tried to reach respondent's place of practice by tele-
16 phone, but respondent was unavailable and had not made
17 provisions for the referral of his telephone calls.

18 E. On August 9, 1976, the date of her appoint-
19 ment, A [REDACTED] K [REDACTED] was unable to reach respondent's
20 place of practice by telephone. She was told that the
21 driver who was supposed to pick her up to bring her in
22 for an examination was not able to come, and that the
23 respondent was not in. The person who answered the tele-
24 phone told A [REDACTED] K [REDACTED] to pull her bandages down
25 and that she would be all right.

26 F. In the following three days A [REDACTED] K [REDACTED]
27 made repeated phone calls to respondent's place of practice,
28 complaining of great pain, but was told that she could not
29 be seen, because respondent's place of practice was too
30 busy.

31 G. On or about August 11, 1976, A [REDACTED] K [REDACTED]

1 noticed a foul smell emanating from the area of the adominal
2 incision, and a great deal of fluid on her clothing adjacent
3 to the incision.

4 H. On or about August 11, 1976, A [REDACTED] K [REDACTED]
5 was admitted to the emergency department of Kaiser Hospital
6 in Harbor City, California, with a severe wound infection
7 and massive abdominal wall cellulitis.

8 I. Following the surgery performed by respondent,
9 A [REDACTED] K [REDACTED] was left with a grossly irregular scar,
10 which is much lower on one side than on the other. She
11 experiences numbness over the right lateral cutaneous nerve
12 of the thigh, and still has excess skin over her lower
13 abdomen.

14 J. Respondent's treatment of A [REDACTED] K [REDACTED]
15 constitutes gross negligence and incompetence in the practice
16 of medicine, as more particularly alleged hereinafter:

17 (1) The location of the scar, with the
18 right side being approximately 1-1/2 to 2 inches
19 lower than the left, indicates a lack of knowledge
20 of the surgical technique.

21 (2) The incorrect placement of the incision,
22 as well as lack of attention to the underlying struc-
23 tures during the surgery, caused the respondent to
24 cut the lateral cutaneous femoral nerve, resulting
25 in a permanent loss of sensation over the right
26 anterior lateral thigh.

27 (3) The lipectomy procedure failed to re-
28 move the patient's "stretch marks," which had been
29 the purpose of the surgery.

30 (4) Respondent abandoned A [REDACTED] K [REDACTED]
31 in that she was unable to obtain any treatment from

1 him or his staff for her wide-spread infection, and
2 was likewise unable to obtain any medication for
3 her pain.

4 WHEREFORE, complainant requests that a hearing be held
5 on the matters alleged herein, and that following said hearing the
6 Division of Medical Quality issue a decision suspending or revok-
7 ing respondent's license; and taking such other action as the
8 Division deems proper.

9 DATED: 5/23/77.

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JOSEPH F. COSENTINO, M.D.
Acting Executive Director
Board of Medical Quality Assurance
State of California

Complainant